CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient Name _____
Address _____
_____
City State zip
Sex ☐ M ☐ F Age_____ Date of Birth_____
Marital Status _____ No. Children_____
Spouse's Name _____

Home Phone_____
Work Phone _____
Cell Phone _____
Social Security Number _____
Occupation _____
Referred by_____
Primary Care Physician Name _____
Primary Care Physician Phone_____

IN CASE OF EMERGENCY

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Cell Phone _____

INSURANCE INFORMATION

☐ I understand that Knopp Chiropractic is NOT a participating provider with any commercial insurance plans except for Medicare, Medicaid and VA. Therefore, if I do not have any of those three insurances I understand that payment is due in full at the time of the visit and an insurance form will be provided for me by the office so I may submit to my insurance.

I also understand that I am responsible to know what my out of network benefits are by calling the 1-800 number on the back of my insurance card for verification. Knopp Chiropractic is not responsible for providing or knowing this information.

☐ I have Medicare, Medicaid or VA, I assign all insurance benefits, if any, to Knopp Chiropractic. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

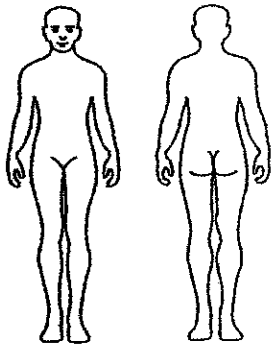
_____ _____
Date Relationship to Patient

PLEASE GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD!

PATIENT CONDITION

Reason for visit_____
When did your first symptoms appear?_____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain)_____
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your ☐Work ☐Sleep ☐Daily routine ☐Recreation
Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down