PATIENT REGISTRATION
Please Print and Complete Both Sides of Form

Name ____
Last First Middle Initial

Address ____
Street Town State Zip Code

Phone ___________________ Work Phone __________________ ext. ________

Cell Phone _______________ Email ___________________________________

Marital Status: S M D W Date of Birth ____/____/_____ Age __________

SS# _______-______-_________ Student? __Full __Part; School:______________

Employer _______________________ Occupation ________________ __Full __Part

Spouse Name____________________ Date of Birth _____________ SS# ____________
Employer ______________________ Work Phone _______________ ext. ______

How were you referred to our office? __________________ (list name if person)

Name of emergency contact: _______________ relation ________ phone ____________

If Patient is a Minor:
Name of Parent/Guardian bringing patient today: __________________ Relation ______
Name of Parent/Guardian responsible for patient's account: _______________________
Relation ____________ Phone _______________ Address _______________________
Date of Birth ______________ SS# __________________ Employer _______________

Re: Minors: I hereby authorize Dr. Michael W. Allard and whomever he may designate as assistants to administer health care and/or x-rays as deemed necessary to ________, this day, ___/___/___. Signed ______________ Relation ________.

HEALTH INSURANCE INFORMATION

Primary Co. ____________________ ID# ____________________ Group#__________
Policy Holder: ___Self ___Spouse ___Parent ___Other:________________________
Date of Birth _______________ SS # ___________________________
Name of Employer Insured _____________________________________

Secondary Co. __________________ ID# ____________________ Group#___________
Policy Holder: ___Self ___Spouse ___Parent ___Other: ________________________
Date of Birth _______________ SS # ___________________________
Name of Employer Insured _____________________________________

Attorney Name:________________________________Atty Phone:_________________

Have you had previous chiropractic care? ___Yes ___No   How long ago? ________

What did you treat for? ____

Name of Primary Care Physician ____________________ Phone _______________

Check One: This visit is related to: ___Auto Accident; Date____________, State_____

___Work Injury; Date__________, reported: Y N

___ Other Injury Case; Date___________, State____

___ Daily Living (not auto or work injury)

___ No Specific Injury/Unknown Cause

Explain in detail, the reason for your visit today. ________________________________

____

How long have you had these symptoms and what do you believe was the cause?

____

____

Mark your pain intensity today: 0----1----2----3----4----5----6----7----8----9----10

No pain   Pain   Extreme pain

What activities/movements are you unable to do? ______________________________

List current and past health conditions: _______________________________________

____

List surgeries you have had done: _______________________________________

List physicians presently treating with and reason: ______________________________

____

List any medications you are taking ____

____

List x-rays, CT-scans, & MRIs taken within the past two years & the facility where taken:

____

Do you smoke?___Y___N   If yes, how many per day? __________________________

Do you consume alcohol?____Y____N   If yes, how many drinks per week? __________

Family Medical History:

Please indicate if any of your family members have been diagnosed with any of the following:

	Mother	Father	Grandparents	Siblings
Heart Disease	______	______	___________	_______
Diabetes	______	______	___________	_______
Cancer	______	______	___________	_______
Arthritis	______	______	___________	_______
Osteoporosis	______	______	___________	_______
High Blood Pressure	______	______	___________	_______
Digestive Disorders	______	______	___________	_______

Personal Health History

Have you in the past or are you presently experiencing difficulty with any of the following:

Dizziness ______________	Bones-Osteoporosis ________	Skin Allergies _______
Heart Trouble___________	Arthritis _________________	Eczema ____________
Diabetes _______________	Headaches ________________	Anemia ____________
Tuberculosis ____________	Asthma __________________	Rheumatic Fever _____
Excessive Urination ______	Neuritis __________________	Digestive Disorder ____
High Blood Pressure ______	Nervousness ______________	Cancer _____________
HIV ___________________	Sinus Trouble _____________	Other ______________

Please read and sign the following:
I hereby authorize direct payment of health benefits to Access to Health Chiropractic Center, due me for services rendered. I agree to provide the necessary information required to process my insurance claims. I agree to sign over all insurance payments to this office received by me, due for services rendered. I understand the above information and guarantee this form was completed fully and correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my health and account status.
I understand that services are my financial responsibility and I agree to adhere to the policies set forth by this office. Signed ____________________ Date______________

Female Patients Only; please read and complete the following:
__ Pregnant: number of months today ______
__ I hereby certify that as of this date I have no indication or reason to believe that I am pregnant. Signed ________________________ Date ____________