

PATIENT REGISTRATION FORM

NAME		HOME #	WORK #
ADDRESS		APT. #	CELL #
		MAY WE CONTACT YOU AT WORK <input type="radio"/> YES <input type="radio"/> NO	
CITY / STATE / ZIP		E-MAIL	
<input type="radio"/> MALE <input type="radio"/> FEMALE	MARITAL STATUS <input type="radio"/> S <input type="radio"/> M <input type="radio"/> D <input type="radio"/> W	DATE OF BIRTH / /	AGE
			SS#
EMPLOYER	EMPLOYER ADDRESS	OCCUPATION	
EMERGENCY CONTACT	ADDRESS	PHONE #	
PRIMARY CARE PHYSICIAN	PHONE #	DATE LAST SEEN / /	
REFERRED BY: <input type="radio"/> YELLOW PAGES <input type="radio"/> INTERNET <input type="radio"/> INS PROVIDER BOOK <input type="radio"/> FRIEND \OTHER WHOM: _____		REASON FOR VISIT: <input type="radio"/> CHIROPRACTIC <input type="radio"/> ACUPUNCTURE <input type="radio"/> MASSAGE THERAPY (CHECK ALL THAT APPLY)	

INSURANCE INFORMATION / METHOD OF PAYMENT

HOW DO YOU PLAN ON PAYING FOR YOUR VISIT? <input type="radio"/> CASH <input type="radio"/> CHECK <input type="radio"/> CREDIT CARD	<input type="radio"/> GENERAL HEALTH INSURANCE	<input type="radio"/> WORKERS' COMPENSATION INSURANCE	<input type="radio"/> AUTO INSURANCE
PLEASE INDICATE BY CHECKING YES OR NO IF YOU HAVE HEALTH BENEFITS (INSURANCE) AVAILABLE THRU THE H.E.R.E.I.U./CULINARY HEALTH FUND <input type="radio"/> YES <input type="radio"/> NO (WHICH INCLUDES LOCAL 226-CULINARY, LOCAL 369-MUSICIANS, LOCAL 165-BARTENDERS ,LOCAL 720-STAGE HANDS)			
NAME OF INSURANCE COMPANY		NAME OF INSURED	
ADDRESS	RELATIONSHIP TO INSURED <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> CHILD <input type="radio"/> OTHER	SS# OF INSURED	
CITY-STATE-ZIP	PHONE #		
POLICY #	GROUP #	CLAIM #	
DO YOU HAVE A SECONDARY INSURANCE <input type="radio"/> YES <input type="radio"/> NO	NAME OF INSURANCE COMPANY	POLICY #	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THE PAIN CLINIC, INC. TO RELEASE TO MY INSURANCE COMPANY AND ITS REPRESENTATIVES ANY INFORMATION NECESSARY TO OBTAIN PAYMENT OF MY BENEFITS. I ALSO AUTHORIZE AND REQUEST THAT MY INSURANCE COMPANY PAY DIRECTLY TO THE PHYSICIAN THE AMOUNT DUE FOR SERVICES RENDERED. I FURTHER AGREE THAT I WILL BE RESPONSIBLE FOR ALL NON-COVERED SERVICES, CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCES. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL CHARGES FOR MY TREATMENT. DELINQUENT ACCOUNTS CAN BE SUBJECT TO FURTHER COLLECTION BY AN OUTSIDE COLLECTION AGENCY OR ATTORNEY. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 90 DAYS. IN THE EVENT YOUR ACCOUNT IS TURNED OVER TO AN OUTSIDE COLLECTION AGENCY OR ATTORNEY, YOU WILL BE RESPONSIBLE FOR ANY AND ALL REASONABLE COLLECTION AND COURT COSTS. I CERTIFY THAT THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT OR GUARDIAN SIGNATURE

DATE

PARENTS CONSENT FOR MINOR CHILDREN

PARENT OR GUARDIAN'S FULL NAME: _____ CHILD'S FULL NAME: _____

I, _____ HEREBY AUTHORIZE _____ TO SEE MY CHILD _____.

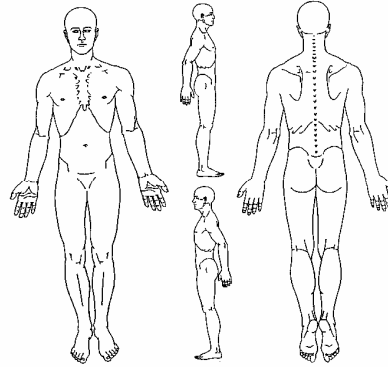
PARENT OR GUARDIAN'S SIGNATURE

DATE

HEALTH HISTORY

PLEASE INDICATE REGION OF COMPLAINT

<input type="radio"/> HEADACHE PAIN
<input type="radio"/> NECK PAIN
<input type="radio"/> UPPER/MID BACK PAIN
<input type="radio"/> LOW BACK PAIN
<input type="radio"/> SHOULDER-ELBOW-WRIST-HAND PAIN
<input type="radio"/> HIP-KNEE-ANKLE-FOOT PAIN
<input type="radio"/> OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN AND SENSATIONS...

KEY

- A** = ACHE
- B** = BURNING
- S** = STABBING
- N** = NUMBNESS
- P** = PINS & NEEDLES
- O** = OTHER

RATE YOUR PAIN INTENSITY (PLEASE CIRCLE)

NO PAIN

EXTREME PAIN

1. RIGHT NOW 0 1 2 3 4 5 6 7 8 9 10

2. AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10

3. AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10



MEDICAL HISTORY

YES NO

<input type="checkbox"/> ARTHRITIC CONDITION	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST MEDICATIONS
<input type="checkbox"/> CANCER	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> DIABETES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HEART PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIC TO MEDICATIONS
<input type="checkbox"/> VASCULAR CONDITION	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> LUNG PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> USUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIES
<input type="checkbox"/> UNUSUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> CURRENTLY PREGNANT	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> EXERCISE REGULARLY	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> HEIGHT
<input type="checkbox"/> SMOKER	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> WEIGHT
<input type="checkbox"/> ALCOHOL	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST SURGERIES / MEDICATIONS
<input type="checkbox"/> ALLERGIES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> BIRTH CONTROL MEDICATIONS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> OTHER			
<input type="checkbox"/>			

IS THIS CONDITION RELATED TO AN INJURY? <input type="radio"/> YES <input type="radio"/> NO IF NO PLEASE PROCEED TO NEXT PAGE	
NATURE OF INJURY <input type="radio"/> AUTO / OTHER <input type="radio"/> WORKER'S COMPENSATION	PLEASE PROCEED TO SECTION # 1 PLEASE PROCEED TO SECTION # 2

SECTION #1 – PERSONAL INJURY

DATE OF ACCIDENT / /	TIME <input type="radio"/> AM <input type="radio"/> PM	LOCATION OF ACCIDENT	
<input type="radio"/> AUTO V AUTO	<input type="radio"/> AUTO V TRUCK	<input type="radio"/> MOTORCYCLE	<input type="radio"/> AUTO V BUS
<input type="radio"/> AUTO V PEDESTRIAN	<input type="radio"/> SLIP & FALL	<input type="radio"/> OTHER	
PLEASE DESCRIBE INJURY			
<input type="radio"/> DRIVER OR <input type="radio"/> PASSENGER	<input type="radio"/> FRONT SEAT OR <input type="radio"/> BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	<input type="radio"/> YES <input type="radio"/> NO
BODY PARTS STRUCK	<input type="radio"/> YES <input type="radio"/> NO	IF YES, PLEASE LIST	
EMERGENCY TREATMENT?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, WHERE?	
PREVIOUS TREATMENT? <input type="radio"/> YES <input type="radio"/> NO	IF YES, BY WHOM?		TYPE OF TREATMENT
LOSS OF CONSCIOUSNESS?	<input type="radio"/> YES <input type="radio"/> NO	WERE YOU BLEEDING?	<input type="radio"/> YES <input type="radio"/> NO
X –RAY TAKEN?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, LIST AREAS	

SECTION # 2 WORKER'S COMPENSATION

WORK RELATED? <input type="radio"/> YES <input type="radio"/> NO	IF YES, ANY WORK LOSS? <input type="radio"/> YES <input type="radio"/> NO	HAVE YOU FILLED OUT FORMS AT YOUR PLACE OF EMPLOYMENT? <input type="radio"/> YES <input type="radio"/> NO
COMPANY NAME		
ADDRESS		
CITY-STATE-ZIP		
TYPE OF BUSINESS		
OCCUPATION	NAME OF SUPERVISOR	
DATE OF INJURY	TIME OF INJURY <input type="radio"/> AM <input type="radio"/> PM	DATE LAST WORKED
DESCRIBE INJURY		
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, UNDERSTAND AND AGREE TO THE NOTICE OF PRIVACY PRACTICES OF **The Pain Clinic, Inc.**, WHICH DESCRIBES THE PRACTICE'S POLICIES AND PROCEDURES REGARDING THE USE AND DISCLOSURE OF ANY OF MY PROTECTED HEALTH INFORMATION CREATED, RECEIVED OR MAINTAINED BY THE PRACTICE.

DATE

SIGNATURE

PRINT NAME

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

THE PRACTICE HAS MADE A GOOD-FAITH EFFORT TO OBTAIN AN ACKNOWLEDGEMENT OF _____'S RECEIPT OF OUR PRIVACY PRACTICES. IN SPITE OF THESE EFFORTS, THE PRACTICE HAS BEEN UNABLE TO OBTAIN A SIGNED ACKNOWLEDGEMENT OF RECEIPT FOR THE FOLLOWING REASONS (CHECK ALL THAT APPLY):

- PATIENT UNAVAILABLE
- PATIENT PHYSICALLY UNABLE
- PATIENT UNWILLING

IN AN EFFORT TO OBTAIN THE PATIENTS ACKNOWLEDGEMENT, THE PRACTICE HAS ATTEMPTED TO PROVIDE PATIENT WITH A NOTICE OF PRIVACY PRACTICES IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- PERSONALLY
- MAIL
- PHONE FOLLOW UP
- OTHER: _____

DATE

SIGNATURE

PRINT NAME