NEW PATIENT REGISTRATION

CONFIDENTIAL PATIENT INFORMATION

First Name:____________________ Middle Initial:____ Last Name:___________________________ SS#:_________- _____-___________

Address:____ City:____________________ State:________ Zip:______________

Home Phone #:____________________ Cellular Phone #:____________________ E-mail Address:_______________________________

Age:______ Birth Date:____/____/______ Marital Status: M S W D How Many Children?_____ Ages:________________________

Occupation:____________________ Employer:___________________________ How Long?_______ Office Phone #:________________

Name of Spouse:______________________ His/Her Occupation:______________________________ Office Phone #:_________________

How did you hear about our office?____

INSURANCE INFORMATION

Primary Insurance:_______________________________________ Policy Holder's Name:_______________________________________

ID/Policy #:____ Group #:____

Date of Birth:____/____/_______ Address:____ Home Phone #:__________________

Employer:______________________________________ Work Phone #:_________________ Relationship to Patient:__________________

Secondary Insurance:_____________________________________ Policy Holder's Name:____

ID/Policy #:____ Group #:____

Date of Birth:____/____/_______ Address:____ Home Phone #:__________________

Employer:______________________________________ Work Phone #:_________________ Relationship to Patient:__________________

Personal Injury:_______________________________ Insured's Name:________________________ ID/Policy #:____________________

Worker's Compensation:________________________ Insured's Name:________________________ ID/Policy #:____________________

CONFIDENTIAL PATIENT HISTORY

What Are Your Symptoms?____

Have you ever had this condition before? Yes / No If yes, when and describe:____

How did it originally occur?____ Has your condition changed recently? Better Worse Same

Is your condition due to an injury at work? Yes / No Days lost from work?________ Date of Accident:____/____/_______

Is your condition due to an automobile or other accident? Yes / No Days lost from work?________ Date of Accident:____/____/_______

Have you received any other treatment for this condition? Describe:____

Have you ever received chiropractic treatment? Yes / No Name of Doctor:______________________________ When?_______________

Please list any major accidents (other than above):____

Please list any operations with dates:____

Please list current medications or drugs:____

Name of primary medical physician:___________________________ Last visit:____/____/_______ Reason:________________________

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my health status, I will inform the doctor.

I authorize my insurance company to pay Holtz Chiropractic all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Holtz Chiropractic to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature:____ Date:_______________________________________