

REGISTRATION

Date: _____

Cell Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: • M • F Age: _____ Birthdate: _____ • Single • Married • Widowed • Separated • Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **Tarrytown Chiropractic, PLLC** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands
right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms
right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs
right/left

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: yes ___ no ___

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

Tarrytown Chiropractic, PLLC
102 South Broadway
Tarrytown, NY 10591

Phone: 914-631-4900
Fax: 833-525-2236

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- asthma pulmonary embolism respiratory arrest
- COPD pneumonia sleep apnea
- emphysema tuberculosis other: _____

Cardiac / Heart and peripheral vascular disease

- chest pain / angina high blood pressure irregular heartbeat, arrhythmia
- heart attack, myocardial infarction heart murmur, valve disorder peripheral vascular disease
- congestive heart failure mitral valve prolapse deep vein thrombosis
- other: _____ bleeding problems

Neurologic Disorders

- stroke or TIA parkinson's cerebral palsy
- peripheral neuropathy MS polio
- other: _____

Bone & Joint Disorders

- osteoarthritis gout osteomyelitis
- rheumatoid arthritis lupus ankylosing spondylitis
- other: _____

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer diverticulitis hepatitis - Type _____
- acid reflux, GERD irritable bowel liver disease
- GI bleed inflammatory bowel disease
- other: _____

Genitourinary Disorders

- urinary tract infection
- kidney problems
- dialysis, kidney failure
- bladder problems
- kidney stones
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
 - skin disorder _____
 - depression
 - thyroid problems
 - psoriasis
 - anxiety
 - sickle cell disease
 - any skin ulcer
 - alcohol or drug dependency
 - high cholesterol or lipids
 - tooth abscess, gingivitis
 - other: _____
- Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
 - tuberculosis
 - sleep apnea
 - COPD or Emphysema
 - other lung : _____
 - heart attack, myocardial infarction
 - congestive heart failure
 - irregular heartbeat, arrhythmia
 - bleeding problems
 - other heart : _____
 - Peripheral neuropathy
 - MS or Parkinson's
 - other neuro : _____
 - osteoarthritis
 - Lupus
 - gout
 - rheumatoid arthritis
 - Other bone & joint: _____
 - acid reflux, GERD
 - inflammatory bowel disease
 - hepatitis - Type _____
 - liver disease
 - other GI : _____
 - kidney problems
 - dialysis, kidney failure
 - diabetes
 - psoriasis
 - high cholesterol or lipids
 - thyroid problems
 - sickle cell disease
 - any skin ulcer
 - Malignant hyperthermia
- Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- Medicare
- Blue Shield
- Auto Accident
- Medicaid
- Major Medical
- Union Plan
- Blue Cross
- Worker's Compensation
- Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address:

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):
