Pain & Wellness Group Registration & Health History

1. Patient Information

Today's Date:_____

Patient Legal Name:(Last, First, Middle)

_____

_____

Address:_____

Street

_____

City State Zip Code

Sex: • Female • Male

Age:_____

Date of Birth:(mm/dd/yyyy) _____/_____/_____

• Married • Single • Minor • Divorced

• Separated •Widowed •Partnered for ___yrs.

SSN:_____

Email:_____

Patient Employer/School:_____

Occupation:_____

Employer/School City, State:_____

_____

*Spouse's Name:*_____

Whom/what may we thank for referring you:

•Family/Friend:_____

• Advertisement • Drove-by/Walk-in

• Internet Search • Insurance

•

Other:_____

2. Insurance & HIPPA Information

Please provide your health insurance card(s) for us to copy into your personal file

Primary Insurance: _____

Secondary Insurance:_____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Pain & Wellness Group &/or Lexington Pain & Wellness Center all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I further agree to allow this office to examine me for further evaluation.

Signature of Patient/Guardian

Print name of Patient/Guardian

Date Relationship to Patient

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability:_____

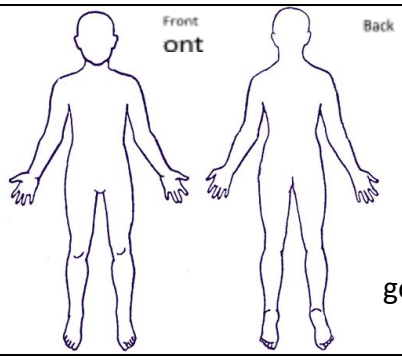
Cell Phone:_(____)_____
Home Phone:_(____)_____
Please circle preferred primary number: Cell or Home?

In case of emergency, contact:
Name:_____
Relationship:_____
Phone Number(s):_____

Is condition due to an accident someone/place is responsible for? • Yes • No Date:_____
Type of accident: • Auto • Work •Other:_____
To whom have you made a report of your accident?
• Auto Insurance • Employer • Work Comp •Other

Attorney Name (if applicable)_____

Reason for visit:_____
When did symptoms appear? _____
Is condition getting progressively worse? • Yes • No
Severity of pain: 1 (least pain) to 10 (severe pain) _____
Describe: •Sharp •Dull •Throbbing •Numbness •Shooting •Stiffness •Other
How often do you have this pain:_____ Is it: •Constant *or* •Come & go



Patient Name: DOB: Date:

6. Health History

What treatment have you received for this condition in the past? •Medications • Surgery • Physical Therapy • Chiropractic Services • None • Other:_____

Date of Last: X-Ray_____ MRI, CT-Scan, Bone Scan_____

Please check "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	• Yes	• No	Epilepsy	• Yes	• No	Kidney Disease	• Yes	• No	Pregnancy	• Yes	• No
									•Vaginal	• Cesarean	
Asthma	• Yes	• No	Fainting	• Yes	• No	Liver Disease	• Yes	• No	Psychiatric Care	• Yes	• No
Bleeding Disorders	• Yes	• No	Fatigue	• Yes	• No	Loss of balance	• Yes	• No	Ringing in Ears	• Yes	• No
Cancer	• Yes	• No	Fractures	• Yes	• No	Menstrual Pain	• Yes	• No	Sleeping Problems	• Yes	• No
Constipation	• Yes	• No	Headaches	• Yes	• No	Migraines	• Yes	• No	Stroke	• Yes	• No
Depression	• Yes	• No	Herniated Disk	• Yes	• No	Multiple Sclerosis	• Yes	• No	Other_____		
Diabetes	• Yes	• No	High Blood Pressure	• Yes	• No	Osteoporosis	• Yes	• No			
Dizziness	• Yes	• No	High Cholesterol	• Yes	• No	Pacemaker	• Yes	• No			
						Polio	• Yes	• No			

EXERCISE	WORK ACTIVITY	HABITS
• None	• Sitting	• Smoking Pack/Day_____
• Moderate	• Standing	• Alcohol Drinks/Week_____
• Daily	• Light Labor	• Coffee/Caffeine Drinks Cups/Day_____
• Vigorous	• Heavy Labor	• High Stress Level Reason_____

*Are you pregnant? • Yes • No Due Date_____ Initials_____

Injuries/Surgeries you have had Description Date

Falls_____

Head Injuries_____

Broken Bones_____

Dislocations_____

Surgeries_____

7. Medications	Allergies	Vitamins/Supplements
_____ _ _____ _ _____	_____ _ _____ _ _____ _	_____ _ _____ _ _____ _

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: Date:

Guardian Signature: Date:
(Only for those signing for the patient)