

**The Center for Total Back Care
Patent Registration Form**

Date: _____

TELL US ABOUT YOU

Name:	Nick Name:	(Circle One)	SSN#:
Address:		M / F	Date of Birth:
City/St/Zip		Referral Name:	
Home Phone:		Referred type:	Doctor / News Paper / Internet / Friend / other:
Work Phone:		Primary Doctor:	
Cell Phone:		Employer:	
email:	Type of work:		

EMERGENCY INFORMATION

Person to Contact in Emergency:	Relation
Address	
City / St / Zip	
Home Phone	Work Phone

REASON FOR VISIT

Visit is a result of (circle one) auto accident / work injury / trauma / sports / gradual onset / chronic pain

Please explain what happened:	Date Condition Began:
	Condition is (circle one) Better / Worse

Is this interfering with work, sleep, daily routine? Y / N

If so please explain:

Tell us about your past care			OK, Tell us about your past health			
Past Treatment	Helpful?		Have you ever had any of the following diseases/medical conditions?			
Y N Physical Therapy	Y N		Y N Frequent Neck Pain	Y N Cancer	Y N	Y N
Y N Surgery	Y N		Y N Lower Back Pain	Y N Chemotherapy	Y N	Y N
Y N Epidural	Y N		Y N Severe Frequent Headaches	Y N Anemia	Y N	Y N
Y N Injections	Y N		Y N Fainting / Seizures / Epilepsy	Y N Difficulty Breathing	Y N	Y N
Y N Nerve Block	Y N		Y N Arm / Leg Pain	Y N Heart Attack	Y N	Y N
Y N Bio Feedback	Y N		Y N Arthritis	Y N Stroke	Y N	Y N
Y N Chronic Care	Y N		Y N Artificial Bones / Joints	Y N Heart Surgery	Y N	Y N
Y N Supervised Exercise	Y N		Y N Asthma / Emphysema	Y N Heart Murmur	Y N	Y N
Y N Back School	Y N		Y N Ulcers / Colitis	Y N Congenital Heart Defect	Y N	Y N
Y N Acupuncture	Y N		Y N Kidney Problems	Y N Mitral Valve Prolapse	Y N	Y N
Y N Chiropractic	Y N		Y N Alcohol / Drug Abuse	Y N Artificial Valves	Y N	Y N
			Y N Hepatitis	Y N Rheumatic Fever	Y N	Y N
Y N Other: _____	Y N		Y N HIV / AIDS	Y N High / Low Blood Pressure	Y N	Y N
Y N _____	Y N		Y N Shingles	Y N Diabetes	Y N	Y N
Y N _____	Y N		Y N Psychiatric Problems	Y N Tuberculosis	Y N	Y N

**The Center for Total Back Care
Patent Registration Form**

Date: _____

Are you taking any medications? Y / N If so, please list:

Please list any other serious medical condition(s) you have ever had:

Please list anything that you may be allergic to:

List past serious accidents:

Family health history (please circle) Diabetes, Cancer, Heart Disease/Stroke, Other:

Do you smoke? Y / N How Much How Long?

Do you wear? (please circle) Heel Lifts, Sole Lifts, Inner soles, Arch supports

What is the age of your mattress? Is it comfortable? Y / N

Do you sleep on your (please circle): Back, Side, Stomach, At an Incline

For Women:

Do you take birth control? Y / N If yes, How Long?

Are you pregnant? Y / N if so, how long? Are you Nursing? Y / N

- FINANCIAL RESPONSIBILITY

Person Responsible	Insured's Name:
Address:	Insured's ID#:
City / St / Zip	Insured's DOB:
Phone	Group Policy #
Relationship to Patient:	Insured's Employer
Insurance Company:	Employers Phone

Please Read & Sign

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. As a courtesy to you, we will usually bill your insurance for you, however, insurance is a contract between you and your insurance company and you are ultimately responsible for all fees incurred as a result of any treatment you receive in this office.

If your account is **not paid within 90 days** of the date service, and no financial arrangements have been made, a **service fee of 25% of the outstanding balance will be added to your account** for collection agency fees, and any other expenses incurred collecting your account.

If this was a result of a motor vehicle accident, your insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment in this office.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or collect on my account.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____