FOX CHIROPRACTIC & Therapy Center

Fox Chiropractic & Therapy Ctr
959 Las Tablas Rd. B4
Templeton, CA 93465

Patient Registration

Name_____ Date_____

Address_____ City/Zip_____

Phone_____ Social #_____ DOB _____

Marital Status _____ Age_____ Number of children_____

Sex M F Perfer not to answer

Occupation _____ Employer_____

Address_____ City/Zip_____ Phone_____

Name of Spouse_____ Spouse's Occupation_____

Employer_____ Phone_____

Language Preference_____ Referred by_____

Emergency Contact_____ Relationship to patient_____

Phone_____

Were you hurt?: (Circle if appropriate) WORK AUTO ACCIDENT OTHER

Please list any Medications/Supplements you are taking:

_____

_____

Are you utilizing insurance for your visit? If yes, please provide a copy of a current card

Family History – Please list immediate family members

Relationship_____ Age_____ Age at death_____Medical conditions _____

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Relationship_____ Age_____ Age at death_____Medical conditions _____

Briefly explain your current complaint/area of pain _____

_____

Date of last x-ray_____ Are you pregnant? YES NO

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Check symptoms you have noticed: Use N if problem Now Use P if problem in the Past Leave blank if OK

( ) Headaches
( ) Head feels heavy
( ) Light headed
( ) Loss of balance
( ) Dizzy
( ) Nervous
( ) Fatique
( ) Loss of hearing
( ) Blurred vision
( ) Chest pain
( ) Pain in shoulder
( ) Muscle spasm in shoulder
( ) Pain in neck
( ) Stiff neck
( ) Muscle spasms in neck
( ) Pain in arm and hand
( ) Pins and needles in arms/hands
( ) Loss of grip strength
( ) Mid back pain
( ) Pain between shoulders
( ) Low back pains
( ) Low back muscle spasm
( ) Pain into buttock
( ) Pain into thigh
( ) Pain down leg
( ) Pain in ankle
( ) Pain in foot

TODAYS PAIN OR PROBLEM STARTED WHEN_____

PAINS ARE: SHARP_____DULL_____CONSTANT_____INTERMITTENT_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE?_____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

ANY HOME REMEDIES_____

PREVIOUS SERIOUS ILLNESS:(Please list & describe) CANCER_____ FRACTURES_____

If you are accepted as a patient you are expected to pay at the end of each visit unless other arrangements are approved

Date_____Patient/Parent Signature_____

This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS
I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid

Date_____Patient's Signature_____

AUTO AND OTHER ACCIDENTS - NOTICE OF LIEN TO ATTORNEY
I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him
I have received a copy of this document

Date_____Patient's Signature_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date_____Attorney's Signature_____