HOPMEADOW CHIROPRACTIC
REGISTRATION FORM

Please Print

Today's date:	

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Street address:	Social Security no.:	Phone numbers:
		Home ( )

P.O. box:	City, State:	Zip Code:	Work ( )
			Best time to call:

Occupation:	Employer and address:	Employer phone no.:
		( )

Whom may we thank for referring you?	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Website / Other

Spouses name:	Spouse's Employer:	Spouse's Birthdate

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Who is responsible for this account?	Relationship to patient	Address (if different):	Phone numbers:
			Home ( )
Is this person a patient here?	❑ Yes ❑ No		Work ( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes ❑ No
Primary Insurance Company	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:
		( )	( )

I the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Bolognese 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature *Date*

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HEALTH HISTORY

Place a mark on Yes or No to indicate if you had any of the following:

AIDS / HIV	❑ Yes ❑No	Goiter	❑ Yes ❑No	Pneumonia	❑ Yes ❑No
Alcoholism	❑ Yes ❑No	Gonorrhea	❑ Yes ❑No	Polio	❑ Yes ❑No
Allergy Shots	❑ Yes ❑No	Gout	❑ Yes ❑No	Prostate Problem	❑ Yes ❑No
Anemia	❑ Yes ❑No	Heart Disease	❑ Yes ❑No	Prosthesis	❑ Yes ❑No
Anorexia	❑ Yes ❑No	Hepatitis	❑ Yes ❑No	Psychiatric Care	❑ Yes ❑No
Appendicitis	❑ Yes ❑No	Hernia	❑ Yes ❑No	Rheumatoid Arthritis	❑ Yes ❑No
Arthritis	❑ Yes ❑No	Herniated disk	❑ Yes ❑No	Rheumatic Fever	❑ Yes ❑No
Asthma	❑ Yes ❑No	Herpes	❑ Yes ❑No	Scarlet Fever	❑ Yes ❑No
Bleeding Disorder	❑ Yes ❑No	High Cholesterol	❑ Yes ❑No	Stroke	❑ Yes ❑No
Breast Lump	❑ Yes ❑No	Kidney Disease	❑ Yes ❑No	Suicide Attempt	❑ Yes ❑No
Bronchitis	❑ Yes ❑No	Liver Disease	❑ Yes ❑No	Thyroid Problems	❑ Yes ❑No
Bulimia	❑ Yes ❑No	Measles	❑ Yes ❑No	Tonsillitis	❑ Yes ❑No
Cancer	❑ Yes ❑No	Migraine Headaches	❑ Yes ❑No	Tuberculosis	❑ Yes ❑No
Cataracts	❑ Yes ❑No	Miscarriage	❑ Yes ❑No	Tumors, Growths	❑ Yes ❑No
Chemical Dependent	❑ Yes ❑No	Mononucleosis	❑ Yes ❑No	Thyroid Fever	❑ Yes ❑No
Chicken Pox	❑ Yes ❑No	Multiple Sclerosis	❑ Yes ❑No	Ulcers	❑ Yes ❑No
Diabetes	❑ Yes ❑No	Mumps	❑ Yes ❑No	Vaginal Infections	❑ Yes ❑No
Emphysema	❑ Yes ❑No	Osteoporosis	❑ Yes ❑No	Venereal Disease	❑ Yes ❑No
Epilepsy	❑ Yes ❑No	Pacemaker	❑ Yes ❑No	Whooping Cough	❑ Yes ❑No
Fractures	❑ Yes ❑No	Parkinson's Disease	❑ Yes ❑No	Other:	
Glaucoma	❑ Yes ❑No	Pinched Nerve	❑ Yes ❑No		

ACCIDENT INFORMATION

Is this condition due to an accident? ❑ Yes ❑ No | Date of injury: / /

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you reported the accident: | Phone: ( )

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

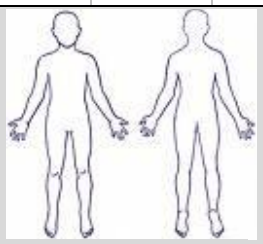
Attorney name and number (if applicable):

PATIENT CONDITION

Reason for visit: | When did your first symptoms appear:

Is this condition getting worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



front back

Type of Pain:

❑ Sharp
❑ Dull
❑ Throbbing
❑ Numbness
❑ Stiffness
❑ Swelling

❑ Aching
❑ Shooting
❑ Burning
❑ Tingling
❑ Cramps
❑ Other

If other, describe:

How often do you have this pain? | Is it constant, or come and go?

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down

What treatment have you already had for this condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other

Name and address of doctors who have treated this condition:

Date of last: Physical_____ Spinal Exam_____ Dental X-Ray_____ Spinal X-Ray_____ Chest X-Ray_____ MRI, CT Scan, Bone Scan_____ Blood Test_____ Urine Test_____

Exercise: ❑ None ❑ Moderate ❑ Daily ❑ Heavy | Work Activity: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Habits: ❑ Smoking ____ packs/day ❑ Alcohol ____ Drinks/week ❑ Coffee/Caffeine____ cups/day ❑ High Stress, reason:_____

Medications / Herbs / Allergies:

Injuries / Surgeries you have had, describe with dates:

Are you pregnant? ❑ No ❑ Yes, due date is _____

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(optional page)

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www.HopmeadowChiropractic.com

Please print your email clearly:

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