Section #1 – Personal Injury

DATE	TIME ○AM ○PM		LOCATION OF ACCIDENT
○ AUTO V AUTO	○ AUTO V TRUCK	○ MOTORCYCLE	○ AUTO V BUS
○ AUTO V PEDESTRIAN	○ SLIP & FALL	○ OTHER	
PLEASE DESCRIBE INJURY			

○ DRIVER OR ○ PASSENGER	○ FRONT SEAT OR ○ BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	○ YES ○ NO
BODY PARTS STRUCK	○ YES ○ NO	IF YES, PLEASE LIST	
EMERGENCY TREATMENT?	○ YES ○ NO	IF YES, WHERE?	
WORK –RELATED?	○ YES ○ NO	IF YES, ANY WORK LOSS?	○ YES ○ NO
LOSS OF CONSCIOUSNESS?	○ YES ○ NO	WERE YOU BLEEDING?	○ YES ○ NO
X –RAY TAKEN?	○ YES ○ NO	IF YES, LIST AREAS	

Section #2 –Workers' Compensation Injury / Employer Information

COMPANY NAME		
ADDRESS		
CITY-STATE-ZIP		
TYPE OF BUSINESS		
OCCUPATION		
DATE OF INJURY	TIME OF INJURY ○AM / ○PM	DATE LAST WORKED
DESCRIBE INJURY		
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]		

Section #3 – Insurance Information / Method of Payment

○ CASH ○ CHECK ○ CREDIT CARD	○ GENERAL HEALTH INSURANCE	○ WORKERS' COMPENSATION INSURANCE	○ AUTO INSURANCE
INSURANCE COMPANY		CLAIM REPRESENTATIVE	
POLICY #	GROUP #	CLAIM #	
ADDRESS			
CITY-STATE-ZIP	PHONE #		
NAME OF INSURED	SS #	○ SELF ○ OTHER	
AUTO MED –PAY INSURANCE COMPANY	POLICY #		

Authorization to Release Medical Information / Financial Agreement

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.

______________________________ PATIENT OR GUARDIAN SIGNATURE

______________ DATE

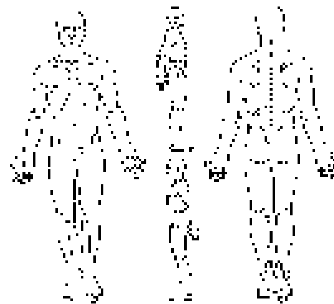
PATIENT REGISTRATION FORM

NAME				HOME #
ADDRESS				WORK #
CITY-STATE-ZIP				CELL #
EMERGENCY CONTACT	PHONE #	SS #		E –MAIL
○MALE ○FEMALE	○S ○M ○D ○W	DATE OF BIRTH		DRIVER LICENSE #

EMPLOYER	OCCUPATION
ADDRESS	CITY-STATE-ZIP
REFERRED BY	PRIVATE PHYSICIAN

PLEASE INDICATE REGION OF COMPLAINT

○ HEADACHE PAIN
○ NECK PAIN
○ UPPER/MID BACK PAIN
○ LOW BACK PAIN
○ SHOULDER-ELBOW-WRIST-HAND PAIN
○ HIP-KNEE-ANKLE-FOOT PAIN
○ OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS...

KEY
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

MEDICAL HISTORY

	YES	NO	
▪ ARTHRITIC CONDITION	○	○	▪ LIST MEDICATIONS/ NUTRITIONAL SUPPLEMENTS
▪ CANCER	○	○	-
▪ DIABETES	○	○	-
▪ HEART PROBLEMS	○	○	-
▪ HIGH BLOOD PRESSURE	○	○	
▪ VASCULAR CONDITION	○	○	I AM INTERESTED IN NUTRITIONAL AND HERBAL RECOMMENDATIONS FOR MY HEALTH PROBLEMS.
▪ LUNG PROBLEMS	○	○	
▪ USUAL CHILDHOOD DISEASES	○	○	
▪ UNUSUAL CHILDHOOD DISEASES	○	○	
▪ CURRENTLY PREGNANT	○	○	▪ ALLERGIES (MEDICATIONS, FOOD ETC.)
▪ EXERCISE REGULARLY	○	○	▪
▪ SMOKER	○	○	▪ HEIGHT
▪ ALCOHOL	○	○	▪ WEIGHT
▪ ALLERGIES	○	○	▪ LIST SURGERIES / HOSPITALIZATIONS
▪ BIRTH CONTROL MEDICATIONS	○	○	-
▪ OTHER			

SPECIFIC INJURY? ○ YES ○ NO	DATE OF INJURY
PREVIOUS TREATMENT? ○ YES ○ NO	TREATMENT TYPE
DOCTOR NAME	PHONE #

NATURE OF INJURY

○ AUTO
○ WORK RELATED
○ HOME / OTHER

COMPLETE SECTIONS 1 & 3 ONLY
COMPLETE SECTIONS 2 & 3 ONLY
COMPLETE SECTION 3 ONLY