Patient Registration (page 1 of 4)

Today's Date_____ **Signature of Patient** _____

Patient Title:*(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. **Nickname**:_____

First Name_____ **Middle**_____ **Last Name**_____ **Suffix**_____

Date of Birth_____/_____/_____ **Age**_____ **SS#**_____

Gender*(check one)* ❑Male ❑Female ❑Unspecified **Children***(circle)* Y / N If yes, ages:_____

Home Address _____**City**_____**State**_____ **Zip**_____

Home Phone_____ **Mobile Phone** _____

Email Address_____

How would you like us to contact you for appointment reminders? *(check one & provide number)*
❑ Phone _____ OR ❑ Mobile Text _____ OR ❑ Not at all
We provide this service to help you avoid a missed appointment charge.

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Retired ❑ Self Employed ❑ Other_____

Employment Information (*If applicable)*

If Employed, Occupation _____ Employer_____

Address _____ Phone _____

Spouse Information (*If applicable)* If married, is your spouse a patient in our office? ❑ Yes ❑ No

Spouse Name _____ Work Phone _____ Cell Phone _____

Does Spouse have the same address as you? If yes, check here: ❑

If home address different than spouse please provide below:

Address _____Hm Phone_____

Guardian Guarantor Information (*If applicable)*

Relationship to patient: ❑ Parent ❑ Grandparent ❑ Foster Parent ❑ Other _____

Guardian Name _____ SSN _____ DOB _____

Address _____

Hm Phone _____ Work Phone _____ Cell Phone _____

Insurance Information(*If applicable)* Please present your insurance card to the front desk for a copy to be made.

Primary Ins _____ Subscriber's Name _____ DOB_____

Patient relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Ins (if any) _____ Subscriber _____ DOB_____

Patient relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Please tell us how you learned about Dr. Funicello:_____

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If current complaint is **due to an accident**, then check the following boxes. If No, *Check here ❑ Not applicable*

Type of Accident: ❑ Auto ❑ Work ❑ Home ❑ Other_____ Date of Accident _____ State ___
Has the Accident been reported? ❑ Yes ❑ No If Yes, whom have you made a report with: ❑ Auto Ins
❑ Employer ❑ Work Comp. ❑ Other_____ Have you hired a legal advisor? ❑Yes ❑No

Have you seen any other healthcare provider for your **current complaint**? ❑ Yes ❑ No
If yes, please indicate the doctor's name_____ and what treatment(s) were rendered:
❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ X-rays
❑ MRI ❑ CT ❑ Injections ❑ Ice / heat ❑ Brace/Ortho device ❑ Other_____
If more than one doctor was seen, please describe _____

Are you currently under a doctor's care for any other condition? ❑ Yes ❑ No
If yes, who and type of treatment:_____

Have you had an **X-ray, CT scan or MRI** within the past month of your head, neck or spine?
❑ Yes ❑ No If yes, explain:_____

Have you noticed a recent change in any of the following bodily functions? *Check here if: ❑ None of these*
❑ Balance ❑ Bowel or Bladder ❑ Breathing ❑ Gait (walking) ❑ Coughing/sneezing aggravates
❑ Vision ❑ Hearing ❑ Weakness ❑ Grip Strength ❑ Other _____

Work Activity: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Other_____

Stress Level: ❑ low ❑ moderate ❑ high Reason:_____

Exercise: ❑ None ❑ Light ❑ Moderate ❑ Heavy If Yes, how often? ❑daily ❑weekly ❑monthly

Vitamins/Herbs/Minerals? ❑Yes ❑No
If Yes, please list:_____

Liquid Intake: Water___cups/day Coffee/Tea___cups/day Alcohol___drinks/wk

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known **allergies** you have had to any **medications**:_____
If no allergies are known, check here: ❑

Dependency on pain relievers?_____ Recreational drug use?_____

Has any doctor **diagnosed you with Hypertension** presently? ❑Yes ❑No
If yes, is it ❑ Mild ❑ Moderate ❑ Severe? Approx. Diagnosis Date:_____

Has any doctor **diagnosed you with Diabetes** presently? ❑Yes ❑No *If yes*, what kind? ❑Type I ❑Type II

Review of Body Systems

Please let us know if you have any of the issues below or specify that you don't have any complaints in those areas of your body.

❑ **No Issues in this section box**

Osteoporosis	❑ Have	❑ Had	❑ No
Arthritis	❑ Have	❑ Had	❑ No
Scoliosis	❑ Have	❑ Had	❑ No
Neck pain	❑ Have	❑ Had	❑ No
Back problems	❑ Have	❑ Had	❑ No
Hip Disorders	❑ Have	❑ Had	❑ No
Knee Injuries	❑ Have	❑ Had	❑ No
Foot/Ankle pain	❑ Have	❑ Had	❑ No
Shoulder issues	❑ Have	❑ Had	❑ No
Elbow/wrist pain	❑ Have	❑ Had	❑ No
TMJ issues	❑ Have	❑ Had	❑ No
Poor posture	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Anxiety	❑ Have	❑ Had	❑ No
Depression	❑ Have	❑ Had	❑ No
Headache	❑ Have	❑ Had	❑ No
Dizziness	❑ Have	❑ Had	❑ No
Pins & needles	❑ Have	❑ Had	❑ No
Numbness	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

High blood pressure	❑ Have	❑ Had	❑ No
Low blood pressure	❑ Have	❑ Had	❑ No
High cholesterol	❑ Have	❑ Had	❑ No
Poor circulation	❑ Have	❑ Had	❑ No
Angina	❑ Have	❑ Had	❑ No
Excessive Bruising	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Asthma	❑ Have	❑ Had	❑ No
Apnea	❑ Have	❑ Had	❑ No
Emphysema	❑ Have	❑ Had	❑ No
Hay fever	❑ Have	❑ Had	❑ No
Shortness of breath	❑ Have	❑ Had	❑ No
Pneumonia	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Kidney stones	❑ Have	❑ Had	❑ No
Infertility	❑ Have	❑ Had	❑ No
Bedwetting	❑ Have	❑ Had	❑ No
Prostate issues	❑ Have	❑ Had	❑ No
PMS symptoms	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Anorexia/bulimia	❑ Have	❑ Had	❑ No
Ulcer	❑ Have	❑ Had	❑ No
Food sensitivities	❑ Have	❑ Had	❑ No
Heartburn	❑ Have	❑ Had	❑ No
Constipation	❑ Have	❑ Had	❑ No
Diarrhea	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Blurred vision	❑ Have	❑ Had	❑ No
Ringing in ears	❑ Have	❑ Had	❑ No
Hearing loss	❑ Have	❑ Had	❑ No
Chronic ear infections	❑ Have	❑ Had	❑ No
Loss of smell	❑ Have	❑ Had	❑ No
Loss of taste	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Skin cancer	❑ Have	❑ Had	❑ No
Psoriasis	❑ Have	❑ Had	❑ No
Eczema	❑ Have	❑ Had	❑ No
Acne	❑ Have	❑ Had	❑ No
Hair loss	❑ Have	❑ Had	❑ No
Rash	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Thyroid	❑ Have	❑ Had	❑ No
Immune disorders	❑ Have	❑ Had	❑ No
Hypoglycemia	❑ Have	❑ Had	❑ No
Frequent infection	❑ Have	❑ Had	❑ No
Swollen glands	❑ Have	❑ Had	❑ No
Low energy	❑ Have	❑ Had	❑ No

❑ **No Issues in this section box**

Fainting	❑ Have	❑ Had	❑ No
Low libido	❑ Have	❑ Had	❑ No
Poor appetite	❑ Have	❑ Had	❑ No
Fatigue	❑ Have	❑ Had	❑ No
Sudden wt loss	❑ Have	❑ Had	❑ No
Sudden wt gain	❑ Have	❑ Had	❑ No
Weakness	❑ Have	❑ Had	❑ No

Is there anything else about your personal medical history that wasn't covered in the above questions?

❑ Yes ❑ No If yes, please describe below (if any):

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Hospitalizations	_____	_____
Other	_____	_____

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Please check boxes to acknowledge policy/statement

❑ Chiropractic Care

I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

❑ Missed & Late Appointments

I acknowledge that I need to provide at least a 24 hour notice if I need to reschedule or cancel an appointment, otherwise I will incur a $25 missed appointment fee. Also, if I arrive 10 or more minutes past my scheduled appointment it will be considered "missed". I understand that if I develop a pattern of missed &/or late appointments I may be released from care and referred to another provider who may be better suited to meet my schedule needs.

❑ Payment Policy

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I also understand payment for services are due at the time of my visit (includes copays, coinsurance &/or deductible being met). Because no one should be without needed care, I understand in the case of financial difficulty I may discuss a manageable and agreed payment schedule with the front office before care begins. I acknowledge I am responsible for bank fees from a returned check plus a $25 fee.

❑ Outstanding Balances

I acknowledge my account will be automatically turned over to a collection agency once delinquent (excludes special financial arrangements). If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement.

❑ Cell Phone Policy

I understand I need to silence my phone while in the treatment rooms for the courtesy of the doctor, staff and other patients in the office. If following this requirement becomes an issue I understand the office reserves the right to release me from care and refer to another provider.

❑ Permission to Contact

I grant permission to receive a call or text (which ever I specified previously) to confirm or reschedule an appointment. I also grant permission to be sent occasional cards, letters, emails or health information as an extension of my care in this office. Excludes if I chose to not be contacted for appointment reminders (on page 1).

❑ Privacy Verification (the full privacy description is also posted in the lobby for your review)

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

❑ Assignment & Release

I hereby authorize and direct the insurance company and/or my attorney to pay directly to Accident & Injury Chiropractic Center or Appomattox Chiropractic & Rehab. I also authorize this office to release any information to any insurance company, its representative or any attorney regarding care received at either office.

❑ General Verification

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I agree that I have read and fully understand the above acknowledgments and policies.

Patient Name (print)_____ Signature_____ Date_____

Name of Custodial Parent or Legal Guardian (print)_____ Sig_____ Date_____