Newburgh Chiropractic
3 Pierces Road, Newburgh, NY 12550 Tel: 845-561-6800

Registration Form

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: □Male □Female Age_____ Birthday_____

□Single □Married □Widowed □Separated □Divorced

Patient SS# _____

PHONE NUMBERS

Home_____Cell _____

In case of an emergency, contact:

Name_____ Relationship_____

Cell/Home Phone _____ Work_____

EMERGENCY CONTACT _____

EMERGENCY NUMBER _____

RELATION _____

Occupation _____

Employer Address_____

Employer Phone _____

Spouse's Name _____

Birthday_____ SS#_____

Occupation_____

Spouse's Employer_____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co _____

Group# _____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name _____

Birthday _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. Pena 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 my all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No

Date_____ Type of Accident □Auto □Work □Other

Attorney Name (if applicable)_____

Whom may we thank for referring you? _____

PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear? _____

Is this condition getting BETTER - WORSE - STAYING THE SAME

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it CONSTANT or does it COME and GO?

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Rate severity of your pain on a scale from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10

Family History

Please indicate if anyone in your immediate family has ever had any of the following illnesses,.

Parents, grandparent, siblings, child: Circle all that apply: cancer, heart disease, stroke, high blood pressure, diabetes, back problems.

HEALTH HISTORY

Please mark to indicate of you have had any of the following:

	Current	Past		Current	Past		Current	Past
AIDS/HIV	____	____	Heart Disease	____	____	Seizures	____	____
Addiction	____	____	Hemorrhoids	____	____	Sensitive to Light	____	____
Alcoholism	____	____	Hepatitis	____	____	Shortness of Breath	____	____
Allergies	____	____	Hernia	____	____	Sinus Problem	____	____
Allergy Shots	____	____	Herniated Disc	____	____	Sleeping Problems	____	____
Anemia	____	____	Herpes	____	____	Stomach Upset	____	____
Anorexia	____	____	High Blood Pressure	____	____	Stroke	____	____
Appendicitis	____	____	High Cholesterol	____	____	Suicide Attempt	____	____
Arthritis	____	____	Indigestion	____	____	Thyroid Problem	____	____
Asthma	____	____	Irritability	____	____	Tonsillitis	____	____
Belching	____	____	Kidney Disease	____	____	Tuberculosis	____	____
Bleeding Disorder	____	____	Leg Cramps	____	____	Tumors, Growths	____	____
Breast Lump	____	____	Liver Disease	____	____	Ulcers	____	____
Bronchitis	____	____	Loss of Balance/vertigo	____	____	Vaginal Infection	____	____
Bulimia	____	____	Loss of Smell	____	____	Venereal Disease	____	____
Cancer	____	____	Loss of Taste	____	____	Vomiting	____	____
Cataracts	____	____	Measles	____	____	Headache / Migraine	____	____
Chest Pains	____	____	Memory Loss	____	____	Neck Pain	____	____
Chicken Pox	____	____	Miscarriage	____	____	Stiff Neck	____	____
Colitis	____	____	Mononucleosis	____	____	Shoulder/Arm Pain	____	____
Constipation	____	____	Multiple Sclerosis	____	____	Pins/Needles Arms/Hands	____	____
Depression	____	____	Muscle Spasms	____	____	Weakness in Arms/Hands	____	____
Diabetes	____	____	Mumps	____	____	Elbow Pain	____	____
Diarrhea	____	____	Nervousness	____	____	Wrist/Hand Pain	____	____
Difficulty Urinating	____	____	Osteoporosis	____	____	Numbness in Fingers	____	____
Dizziness/Vertigo	____	____	Pacemaker	____	____	Hands/Feet Cold	____	____
Ears Ring	____	____	Parkinson's Disease	____	____	Back Pain	____	____
Emphysema	____	____	Pinched Nerve	____	____	Pins & Needles Legs/Feet	____	____
Fainting	____	____	Pneumonia	____	____	Knee Pain	____	____
Fatigue	____	____	Polio	____	____	Weakness in Legs	____	____
Fractures	____	____	Prostate Problem	____	____	Numbness in Feet/Toes	____	____
Gall Bladder	____	____	Prosthesis	____	____	Swelling Joints /Arthritis	____	____
Glaucoma	____	____	Psychiatric Care	____	____			
Goiter	____	____	Rheumatoid Arthritis	____	____	Other_____	____	____
Gout	____	____	Scoliosis	____	____			

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____

Are you pregnant? □ Yes □ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Supplements