PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_____________________________ (First)___________________________ (MI) _________

Preferred Full Name (if different from above): ___________________________

Home Phone Number (landline):______________________ Cell:_____________________ Work: ___________________

Address: ____

City, State, Zip: ____

Email Address:____ Date of Birth: _______________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer
☐ Choose not to disclose Additional Gender Category not listed _____________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Choose not to disclose ☐ Other not listed ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Swahili ☐ Portuguese ☐ Arabic
☐ Indian: Hindi, Tamil, Gujarati etc ☐ Russian ☐ Vietnamese ☐ Haitian ☐ Albanian ☐ Burmese ☐ Cambodian
☐ Creole Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Other not listed__________

Patient Social Security Number:______-______-_______

RESPONSIBLE PARTY INFORMATION *(If not self)*

(Information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self Check here is address and telephone information is same as patient ☐

Responsible Party Name: (Last)_____________________________ (First)___________________________ (MI) _______

Date of Birth: MM_____/ DD_____/ YYYY_________ Sex: ☐ Female ☐ Male

Address: ____

City, State, Zip: ____

Responsible Party Social Security Number:______-______-_______ Phone Number:_________________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last)____________________________ (First)_______________________________

Phone Number:_______________________________________ Do you have a living will: ☐ Yes ☐ No

Emergency contact relationship to patient: ____ ☐ Guardian

Address: ____

City, State, Zip: ____

Home Phone:_______________________________________ Work Phone:___________________________ Ext.________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____________________________________Date:_______________

Printed name of patient or personal representative:___________________________ Relationship to patient: ______________

Neuro Health History

Patient Name: ____________________________ Date of birth: ________________

Reason for visit today: ____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _______________

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____________________

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ______________

Do you or have you used illegal drugs? | YES | NO If yes, please identify what drug(s) __________________________________

Allergies? YES NO (If yes, please identify) ____

Current Medications	Dosage

Previous Surgery/Hospitalization	Date

Last Colonoscopy: ___________________ **Flu Vaccine:** _____________________ **Pneumonia Vaccine:** ________________

Female patients –
Last Mammogram: _______________ **Last Pap Smear:** ______________ **Do you take Oral Contraceptives?** YES NO

Diabetic Patient: When was your last eye exam? _________________ Where? _______________________

Have you ever had any of the following? *Circle all that apply*:

Asthma Stomach Problems Bladder Problems Jaundice-Liver Gout Alcoholism Kidney Disease Prostate Skin Disease

Joint Disease Stroke Epilepsy-Seizures Depression-Anxiety Thyroid Blood Clot High Blood Pressure Tuberculosis

Diabetes Cancer Lung Disease Heart Disease Psychiatric Disorder Difficulty with Balance Fainting Spells Weakness

Double or Blurred Vision Difficulty with Speech Disorientation Problems with Memory

65 and Over: Have you fallen in the past year? ☐ YES ☐ NO If yes, do you know the cause of your fall? _________________

Do any of these conditions run in your family? *Circle all that apply*:

Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes Psychiatric Disorder Heart Disease

Primary care physician information:

Name:____Phone number: ____

Address: ____

Pharmacy information:

Name:____Phone number: ____

Address: ____

How did you hear about us? Circle any that apply:

Website Family/Friend Internet Search Former or current patient Website Insurance Printing/Advertising Walk-In

Physician (please specify): ____

Other (specify): ____

Patient Name:____

PAIN ASSESSMENT

Do you experience pain as part of your daily life? ❑ Yes ❑ No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

____

____

____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? ________________

PRIOR STUDIES

Have you had any prior studies? Please write the most recent dates for each:

STUDY:	DATE(s):	BODY PART STUDIED:	RESULTS:
XRAY			
MRI			
CT SCAN			
EMG			
Myelogram			
Bone Density			
Other:			

TREATMENTS

Have you had any of the following treatments? Please write the most recent dates for each:

TREATMENT:	DATE(s):	PROVIDERS:	EFFECTIVENESS:
Physical Therapy			
Home Exercise Program			
Chiropractor			
Acupuncture			
Epidural Injections			
Trigger Point Injections			
Facet Injections			
Surgery			
Medications			
Massage			
Other			

HANDEDNESS ❑ Right Handed ❑ Left Handed

The information on this form is accurate to the best of knowledge:

Patient Signature____ Date____________