

PATIENT REGISTRATION FORM (eCW)

(Please print)

PATIENT INFORMATION

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 _____