WELCOME TO **HORN LAKE CHIROPRACTIC CENTRE** SPEEDY REGISTRATION

Print out this form, fill it out and bring it with you to speed up your wait time on first appointment.

1. ABOUT YOU

- Today's Date _________/_________/_________ File # ______________________________
- **Patient Name**: (last)____(first)________________________
- What do you prefer to be called? __________________________ [ ] Male [ ] Female
- Birthdate: _________/_________/_________ Age: _______ SS#: ____________________________
- Mailing Address: ____
  (City)___________________________________(State)___________________(Zip)________________
- Home Phone #: _____________________ Work Phone #: ______________________ Ext: __________
- Other Phone #s: ____
- E-Mail Address: ____
- Referred By: ____
- Employer's Address: ____
- Employer: ____ How Long? _________
  (City)___________________________________(State)____________________(Zip)_______________
- Occupation: ____
- Status: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed
- Spouse's Name: ____
- Do you have children? [ ] Yes [ ] No How many? ____________

2. INSURANCE INFO

Primary Insurance

- Company Name: ____
- Address: ____
  (City) ___________________________________ (State) ___________________ (Zip) _____________
- Phone #: ______________________________ Insured's SS#: _________________________________
- Group # (Plan, Local, or Policy #): ____
- Insured's Name: ____
- Relation: __________________________________ Date of Birth: _________/_________/_________
- Insured's Employer: _________________________________

Secondary Insurance

- Company Name: ____
- Address: ____
  (City) ___________________________________ (State) ___________________ (Zip) _____________
- Phone #: ______________________________ Insured's SS#: _________________________________

- Group # (Plan, Local, or Policy #): ______________________________
- Insured's Name: ______________________________
- Relation: ______________________ Date of Birth: ______/______/______

  Insured's Employer: ______________________

3. REASON FOR VISIT

- The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic. (Explain what happened): ______________________________

  ____
- Please describe the pain and its location: ______________________________

  ____
- When did condition begin? ______/______/______
- Is this condition getting worse? [ ] Yes [ ] No [ ] Constant [ ] Comes and goes
- Is this condition interfering with your (*Please circle*): work, sleep, or daily routine. If so, please explain: ______________________________
- Have you had this or similar conditions in the past? [ ] Yes [ ] No If so, please explain: ______

  ____
- Have you been treated by a Medical Physician for this condition? [ ] Yes [ ] No If so, where? ___

  ____
- Have you ever been treated by a Chiropractor before? [ ] Yes [ ] No If so, whom? ________

  ______________________________Phone #: ____________________

4. IN EVENT OF EMERGENCY

- Who should we contact? ______________________________

  Relation:______________ Home Phone #:____________ Work Phone #:____________

  Who is your Medical Doctor? ______________________ Phone #: ____________

5. ACCOUNT INFO

- Name: ______________________________ Relation: __________________
- Billing Address: ______________________________

  (City) ______________________ (State) ______________ (Zip) ______________
- SSN: ______________ D.L. # ______________ Work Phone #: ______________
- **Payment method:** [ ] CASH [ ] Check [ ] Credit Card – Enter # (if accepted) ________________

________ (initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

HEALTH HISTORY

Are you taking any of the following medications?

[ ] Nerve pills [ ] Pain killers (including aspirin) [ ] Muscle relaxers [ ] Stimulants [ ] Blood thinners [ ] Tranquilizers

[ ] Insulin [ ] Other (s)____

Do you have or ever had any of the following diseases or conditions:

Y N	Heart Attack/Stroke	**Y N**	Heart Surg./Pacemaker	**Y N**	Heart Murmur
Y N	Congenital Heart Defect	**Y N**	Mitral Valve Prolapse	**Y N**	Artificial Valves
Y N	Alcohol/Drug Abuse	**Y N**	Venereal Disease	**Y N**	Hepatitis
Y N	HIV+/Aids	**Y N**	Shingles	**Y N**	Cancer
Y N	Frequent Neck Pain	**Y N**	Emphysema/Glaucoma	**Y N**	Anemia
Y N	High/Low Blood Pressure	**Y N**	Psychiatric Problems	**Y N**	Rheumatic Fever
Y N	Severe/Frequent Headaches	**Y N**	Kidney Problems	**Y N**	Ulcers/Colitis
Y N	Fainting/Seizures/Epilepsy	**Y N**	Sinus Problems	**Y N**	Asthma
Y N	Diabetes/Tuberculosis	**Y N**	Difficulty Breathing	**Y N**	Chemotherapy
Y N	Lower Back Problems	**Y N**	Artificial Bones/Joints	**Y N**	Arthritis

Please list any other serious medical condition(s) you have or ever had: ______________________________

____

Please list anything that you may be allergic to: ____

List previous surgeries/treatments with dates: ____

List any **past** serious accidents with dates: ____

Family Health History: ____

Do you: Take Supplements or Vitamins? [ ] Yes [ ] No

Are you on a special diet: [ ] Yes [ ] No Since: _______/_______/_______

Do you smoke? [ ] No [ ] Yes/How Much?________________ How Long? __________________

Are you wearing: [ ] Heel lifts [ ] Sole lifts [ ] Inner soles [ ] Arch supports

What is the age of your mattress: ________ Is it comfortable? [ ] Yes [ ] No

For women: Are you taking Birth Control? [ ] Yes [ ] No

Are you pregnant? [ ] No [ ] Yes/How long? _______ Nursing? [ ] Yes [ ] No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature____ Date _____/_____/_____

[ ] Adult Patient [ ] Parent or Guardian [ ] Spouse