

## Nesnick Family and Sports Chiropractic Patient Registration

**Please fill out every line as accurately as possible. Do not leave any lines blank.**

Name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: Male or Female

Employment Status: Employed Unemployed Retired Student Other: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**Financial / Insurance Information: Please allow us to make copies of all of your insurance cards as well as your driver's license. The following information is necessary to process insurance claims.**

Primary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

I authorize the release of any medical information necessary to process my claims. I hereby authorize Nesnick Family and Sports Chiropractic to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company be made directly to Nesnick Family and Sports Chiropractic. I permit a copy of the authorization to be used in place of the original. My insurance company or I may revoke this authorization at any time. This revocation must be submitted to Nesnick Family and Sports Chiropractic in writing.

I am responsible for all copays/coinsurances, which are due and payable at the time services are rendered, as well as deductible amounts. If for some reason insurance denies my claims, I am responsible for these balances as well. If further action ever becomes necessary and is taken in order to collect any delinquent balance due on my account, I agree to pay for all collection, attorney, and court fees incurred by Nesnick Family and Sports Chiropractic for the collection of any and all balances due on my account. I am aware that 1.5% interest is assessed on all account balances each month.

By my signature below, I acknowledge: I have read and understand the preceding statements regarding my insurance, as well as my financial responsibilities, including if insurance does not pay. I am responsible for any outstanding balance on my account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Check Any Of The Following You Have Had In The Past 6 Months:**

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urination

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- General Stiffness
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/ Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**MALE/FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain
- Breast Pain/Lumps
- Prostate Dysfunction
- Sexual Dysfunction
- Other Problems

**FEMALES ONLY**

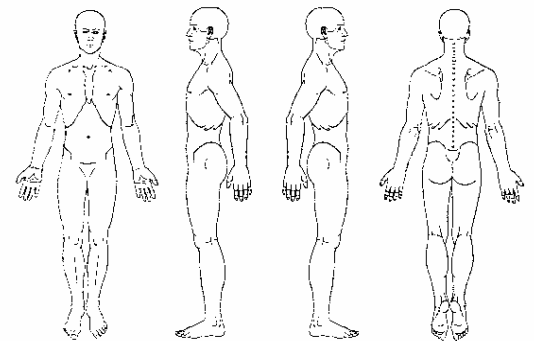
When was your last period? \_\_\_\_\_

Is there ANY possibility that you may be pregnant?  
 Yes No Not Sure

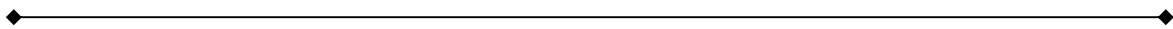
**DESCRIPTION & LOCATION OF PAIN**

Please mark the location of pain with the following descriptions:

R – Radiating T – Tingling N - Numbness



Place a mark, at a place somewhere on the line corresponding to the level of pain for your chief complaint.



No pain

Severe pain

**Current Health Condition**

Health Condition You Are Here For \_\_\_\_\_

Other Doctors Seen For This Condition \_\_\_\_\_

Type of Treatment \_\_\_\_\_ Results \_\_\_\_\_

When Did This Treatment Begin? \_\_\_\_\_ Has This Occurred Before? Yes or No

Is Condition: Job Related Auto Accident Home Injury Fall Other \_\_\_\_\_

Are You Currently Taking ANY Medications? \_\_\_\_\_

**Past Health History**

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken

Major Accidents or Falls \_\_\_\_\_

Hospitalization \_\_\_\_\_