Patient Registration & History Date _____

Patient Information

Patient Name: _____ Birthdate: _____ Age:___

Marital Status: _____ Sex: _____ Height: _____ Weight: _____

Employer/School: _____

Occupation:_____

Patient Local Address: _____

Patient Full-Time Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Relationship: _____

Primary Insurance Information

Responsible Party Name: _____ Birthdate: _____

Social Security Number: _____ Relationship To Patient: _____

Insurance Company: _____ Group Number: _____

Secondary Insurance Information

Responsible Party Name: _____ Birthdate: _____

Social Security Number: _____ Relationship To Patient: _____

Insurance Company: _____ Group Number: _____

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company(ies) and assign directly to **Dr. Taylor** 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 authorize the use of my signature on all insurance submissions.

Dr. Taylor may use my health insurance information and may disclose such information to the above mentioned Insurance Company(ies) and their agents for the purposes of obtaining payment for services and determining insurance payments for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed date below.

Signature of Responsible Party: _____

Print Name of Responsible Party: _____

Date: _____ Relationship to Patient:_____

Accident Information

Accident related: _____ Date of accident: _____ Type of accident: _____

Accident Been Reported: _____ Attorney: _____

Consent to Treat

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition.

Signature of Patient: _____

Print Name of Patient: _____

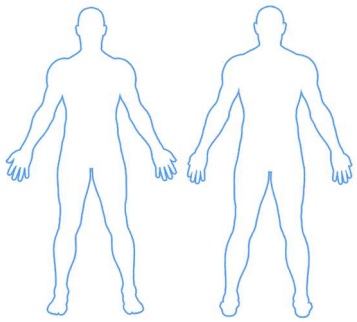
Patient History – Name: _____ Date _____

Patient Condition

Reason for Visit: _____

When did symptoms appear? _____ Is the condition getting progressively worse? _____

Mark X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain at best ___(1-10) 1=Low 10=High

Rate the severity of your pain at worst ___(1-10) 1=Low 10=High

Rate the severity of your pain now ___(1-10) 1=Low 10=High

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

Is the pain constant or come and go? (Circle One)

Does it interfere with your ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

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

Activities or movements that relieve the pain ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lying Down

Health History

What treatments have you already received for your condition? _____

Date of Last: X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No to indicate if you have any of the following

Aids/HIV	__ Yes __ No	Goiter	__ Yes __ No	Pacemaker	__ Yes __ No
Appendicitis	__ Yes __ No	Gout	__ Yes __ No	Parkinson's Disease	__ Yes __ No
Arthritis	__ Yes __ No	Heart Disease	__ Yes __ No	Pinched Nerve	__ Yes __ No
Asthma	__ Yes __ No	Hepatitis	__ Yes __ No	Pneumonia	__ Yes __ No
Bleeding Disorders	__ Yes __ No	Hernia	__ Yes __ No	Polio	__ Yes __ No
Bronchitis	__ Yes __ No	Herniated Disk	__ Yes __ No	Prosthesis	__ Yes __ No
Cancer	__ Yes __ No	High Blood Pressure	__ Yes __ No	Psychiatric Care	__ Yes __ No
Cataracts	__ Yes __ No	High Cholesterol	__ Yes __ No	Rheumatoid Arthritis	__ Yes __ No
Chemical Dependency	__ Yes __ No	Kidney Disease	__ Yes __ No	Stroke	__ Yes __ No
Chicken Pox	__ Yes __ No	Liver Disease	__ Yes __ No	Thyroid Problems	__ Yes __ No
Diabetes	__ Yes __ No	Measles	__ Yes __ No	Tonsillitis	__ Yes __ No
Emphysema	__ Yes __ No	Migraine Headaches	__ Yes __ No	Tuberculosis	__ Yes __ No
Epilepsy	__ Yes __ No	Mononucleosis	__ Yes __ No	Tumors, Growths	__ Yes __ No
Fractures	__ Yes __ No	Multiple Sclerosis	__ Yes __ No	Ulcers	__ Yes __ No
Glaucoma	__ Yes __ No	Osteoporosis	__ Yes __ No	Other _____	

Smoking – Packs/Day _____ Alcohol – Drinks/Week _____ Caffeine Drinks – Cups/Day _____

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

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:

Mail ____;

Email ___; at email address_____;

Telephone Numbers ___; _____ Voice mail ___; Text message ___;

By checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

Mail ____;

Email ___; at email address_____;

Telephone Numbers ___; _____ Voice mail ___; Text message ___;

By checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____

Patient Name (please print) Date

_____ _____

Name of Parent, Guardian or Patient's legal representative (please print) Date

_____ _____

Patient Name (signature) Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHARTS AND MAINTAINED FOR SIX YEARS

List below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____