WELCOME

PATIENT INFORMATION

Date _____

Patient _____

Address_____

_____

City State Zip

Home Phone _____

Work Phone_____

Cell Phone _____

Email Address _____

Patient SS# _____

Sex: __ M __F Age____ Date of Birth_____

__ Single __ Married __Widowed __Separated __ Divorced

Occupation _____

Employer _____

Employer Address_____

_____

Spouse's Name _____

Date of Birth _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Insurance Co. _____

ID# _____

Subscribers Name _____

Date of Birth _____ SS#_____

Relationship to Patient_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Matlaga and/ or Dr. Anderson 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICAL HISTORY

_____

_____

_____

_____

CURRENT CONDITION

Reason for Visit _____

When did symptoms appear?_____

Is condition getting worse? __ Y __ N __ Unknown

Is pain constant or come and go? _____

Does it interfere with your:

____ Work ___ Sleep ___ Daily Activity ___ Recreation

Activities or Movements that are painful to perform:

____ Sitting ___ Standing ___ Walking

____ Bending ___ Lying Down

Pain Scale

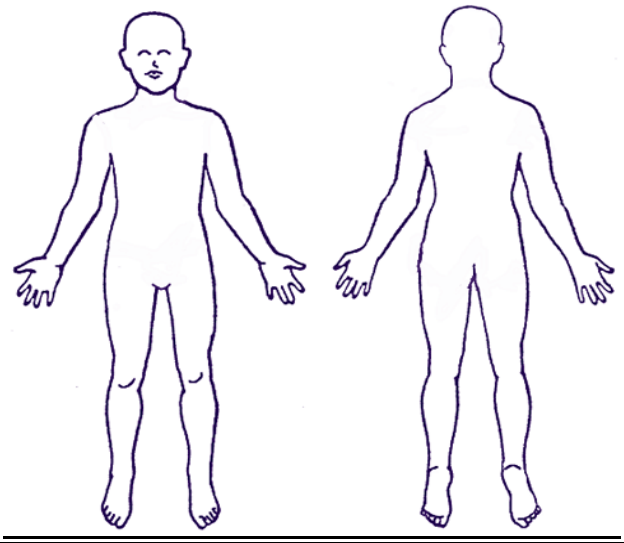
Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE MILD MODERATE SEVERE

Place an "X" on the drawing below on areas causing you pain and a letter describing it.

A= ACHE
B= BURNING
S= STABBING
N= NUMBNESS
P= PINS & NEEDLES



WELCOME BACK

PATIENT INFORMATION

Date _____

Patient _____

Address_____

_____

City State Zip

Email Address_____

Home Phone _____

Work Phone_____

Cell Phone _____

Sex: __ M __F Age____ Date of Birth_____

__ Single __ Married __Widowed __Separated __ Divorced

Occupation _____

Who may we thank for your referral to our office? _____

INSURANCE

Do you have new insurance? ____ Yes ___ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Green Hill Chiropractic 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICAL HISTORY

_____

_____

_____

_____

CURRENT CONDITION

Reason for Visit _____

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