ROCHESTER CHIROPRACTIC & PREGNANCY
Patient Registration & History

Name: First_____ Last _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Birth Gender: M/F I Identify as: _____ Marital Status: M/S/D/W
Phone No: Home: _____ Cell: _____Work: _____
Employment Status: Full time / Part time/ Retired / Self-Employed /Unemployed / Student
Employer Name: _____
Employer Address: _____
Dominant Hand: Left / Right / Both
EMERGENCY CONTACT: _____ Phone No: _____
Relationship: _____
Primary Care Physician: _____ Phone No: _____
Address: _____
FEMALE PATIENTS: OB/GYN: _____ Date Last Seen: _____
Address: _____ Phone No: _____
Are you currently pregnant or trying to become pregnant? YES/ NO If yes, ____ weeks? Due Date: _____
Whom may we thank for your referral? _____

INSURANCE INFORMATION Self Pay Patients N/A

Primary Insurance: _____Effective Date: _____
Subscriber ID#: _____Subscriber's Name: _____
Subscriber's DOB: _____ Relationship to Patient: _____
Secondary Insurance: _____ Effective Date: _____
Subscriber ID#: _____Subscriber's Name: _____
Subscriber's DOB: _____ Relationship to Patient: _____

ASSIGNMENTS OF BENEFITS & AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance coverage with the company(s) stated above, and I assign the office of Dr. Nicole Clemente all insurance benefits directly, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance, including any settlement made in my behalf**.** **INITIAL**: ____
I hereby authorize the Practice/Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. If I have supplied the wrong insurance information or failed to provide up-to-date information, I understand I may be responsible for the total charge of my medical appointment. **INITIAL**: ___
All payments co-pays/ deductible co-ins are due on the date of service. **INITIAL: ____** If after 60 days payment is not received this office reserves the right to send your bill to collections. If this occurs, you will be responsible for our fees plus any fees from the collection agency. I understand that if I miss or fail to provide 24 hrs. notice of cancellation of my appointment, a fee of **$50** will be charged to my account and after 3 violations this office has the right to dismiss you from care. **INITIAL**: ____ I affirm that the information I have provided above is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in this medical status. A copy of this signature is as valid as the original.

X Signature: _____ Date: _____
Witnessed: _____ Date: _____

PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____
Is your condition getting (circle one): Better Worse Staying the Same?
Rate your pain on a scale from 1(least pain) to 10(severe pain): Now: _____ At its worst: _____
What are you feeling? (Circle all that apply) Sharp, Dull, Throbbing, Numbness, Aching, Cramping
Burning, Tingling, Stiffness, Stabbing, Dizzy, Spasms, Other: _____

How often do you experience this problem? _____
Is this constant or does it come and go? _____
Does it interfere with your: (circle all that apply) Work, Sleep, Daily Routine, Recreation?
Other: _____

Painful Activities: (circle all that apply) Sitting, Standing, Walking, Bending, Lying Down, Sleeping
Other: _____
What treatments have you received for this? _____

Health History

Do you exercise? YES/NO If yes, what? _____

Do you drink Caffeine? YES/NO cups per day: _____ Do you smoke? YES/NO Frequency: _____

Alcohol YES/NO drinks per week? _____ Do you use recreational/medicinal drugs? YES/NO _____

Please list ALL medications, vitamins, minerals and/or herbs you are currently taking:_____
_____
_____

Please list ALL surgical procedures, broken bones, head injuries and hospitalizations:_____
_____
_____
Please list ALL allergies:
_____

Family History (check here ____ if adopted)

Please circle if any immediate family members (**Grandparents, Parents, Siblings**) have any of these Diagnosis?

Heart Disease	Kidney Disease	Circulation Problems	Migraines	High Cholesterol
Arthritis	Stomach Problems	Thyroid Disease	Stroke	
Rheumatoid Arthritis	Osteoporosis	Mental Illness	Lung Disease	
Seizures	High Blood Pressure	Cancer (specify): _____		
Diabetes	Back Problems	Other, Not Listed: _____		

Do you currently have, or in the past had any of the following conditions? (Circle all that apply)

General Fatigue	Bladder Infection	Joint Swelling/Stiffness	Birth Control, Type: _____
Depression	Frequent Urination	Arthritis	Breast Tenderness
Anxiety	Painful Urination	Rheumatoid Arthritis	Breast Lumps
Dermatitis	Loss of Bladder Control	Ankylosing Spondylitis	Irregular Menstrual Flow
Eczema	Prostate Problems	Lupus	Profuse Menstrual Flow
Psoriasis	Benign Prostatic Hyperplasia	Raynaud's Syndrome	PMS
Asthma	Kidney Disease	Celiac Disease	Endometriosis
Chronic Cough	Kidney Stones	Multiple Sclerosis	Poly Cystic Ovarian Disease
Emphysema	Loss of Bowel Control	Myasthenia Gravis	Number of Pregnancies_____
Respiratory Disease	Constipation	Other Autoimmune _____	Number of Births: _____
Chronic Sinusitis	Diarrhea	Angina	Single: _____
Difficulty Swallowing	Irregular Bowel Habits	DVT Thrombosis	Multiple: _____
Excessive Thirst	Irritable Bowel Syndrome	Heart Attack, Date: ____	Miscarriages: _____
Diabetes Type I	Ulcerative Colitis	Aortic Aneurysm	Tumor Explain_____
Diabetes Type II	Crohn's Disease	High Blood Pressure	Cancer/ Type: _____
Thyroid Disease	Acid Reflux	High Cholesterol	_____
Hashimoto's Disease	Hepatitis, Type: _____	Rapid Heartbeat	_____
Grave's Disease	Liver/Gallbladder	Tachycardia	Other, not listed:
Headaches	Hepatitis A, B, C	Bradycardia	_____
Migraines	Ulcer	Stroke, Date: _____	_____
Jaw Pain/ TMJ	Blood Disorder, Type: _____	Loss of Appetite	_____
Tinnitus (ringing in ear)	Osteoporosis	Ab-norm. Weight Gain	
Hearing Loss	Scoliosis	Ab-norm. Weight Loss	
Visual Disturbances	Epilepsy	Anorexia/ Bulimia	
Dizziness	Bell's Palsy	Abdominal Pain	
Vertigo	Fibromyalgia	HIV/AIDS	
Fainting		Behavioral Disorders _____	
		ADHD	

Doctors Notes: _____
_____
_____
_____
_____

If UNDER 18, Provide Consent to Treat a Minor:

I hereby authorize **Dr**._____ and whomever he/she may so designate as his/her assistant(s) to administer treatment as the doctor deems necessary for my son/daughter (circle one), (Child's Name)_____. I (Parent/Guardian) will personally be responsible for all payments, co-pays and/or deductibles that are not covered by my insurance and be responsible to keep insurance information up to date with this office.

Name of parent/guardian: _____
Signature of parent/guardian: _____ Date: _____
Witnessed: _____ Date: _____