ROCHESTER CHIROPRACTIC & PREGNANCY
Patient Registration & History

Name: First_____ Last _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Gender: Male/Female 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 Pregnant, Due Date: _____

***SELF-PAY PATIENTS ☐N/A** **INSURANCE INFORMATION**
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 or not 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 there will be a **$10** charge added to my account and I accept full responsibility for the total charge of my medical appointment. **INITIAL:**_____ All payments are due on the date of service. there will be a **$10** charge for non-payment. **INITIAL:**_____ After 60 days if payment has not been received this office reserves the right to send your bill to collections. If this occurs, you will be responsible for our fees and any fees from the collection agency. I also understand that if I no-show for my appointment, a **$30** charge will be added to my account and 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 worse: _____

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 How many per week? _____ Do you use recreational 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 Depression/Anxiety Dermatitis/Rash/Eczema Asthma Chronic Cough Emphysema Chronic Sinusitis Difficulty Swallowing Excessive Thirst Diabetes Type I Diabetes Type II Headaches Migraines Jaw Pain/ TMJ Tinnitus (ringing in ear) Visual Disturbances Dizziness Fainting Respiratory Disease	Bladder Infection Frequent Urination Painful Urination Prostate Problems Kidney Disease Kidney Stones Loss of Bladder Control Loss of Bowel Control Constipation/Diarrhea Irregular Bowel Habits Irritable Bowel Syndrome Colitis Hepatitis, Type: _____ Liver/Gallbladder Thyroid Disease Ulcer Blood Disorder, Type: ____ Osteoporosis Scoliosis Loss of Hearing	Joint Swelling/Stiffness Arthritis Rheumatoid Arthritis Lupus Angina Heart Attack, Date:____ Aortic Aneurysm High Blood Pressure High Cholesterol Rapid Heart Beat Stroke, Date: _____ Ab-norm. Weight Gain/Loss Anorexia/ Bulimia Abdominal Pain Loss of Appetite HIV/AIDS Epilepsy Bell's Palsy Fibromyalgia	Birth Control, Type: _____ Breast Tenderness Breast Lumps Irregular Menstrual Flow Profuse Menstrual Flow PMS PCOS Endometriosis Poly Cystic Ovarian Disease Number of Pregnancies_____ Number of Births: Single: _____ Multiple: _____ Miscarriages: _____ Tumor Explain_____ _____ Cancer Type: _____ _____ _____ Other, not listed: _____ _____ _____ _____

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),_____. I (Parent/Guardian) will personally be responsible for all payments, co-pays and/or deductibles that are not covered by your 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: _____