ATLAS CHIROPRACTIC

# PATIENT FORM

## PATIENT INFORMATION

Name: _____

Preferred to be called _____

DOB _____ Age _____ ☐ Male ☐ Female

Address _____

City & State _____

Social Security Number _____ Email Address _____

Cell Number _____ Home Number _____ Work Number _____

Employer _____ City/State _____ ☐ FT ☐ PT

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about us? _____

## INSURANCE INFORMATION

Policy Holder _____ DOB _____ Relationship to Patient _____

Insurance Company _____ Name of Employer _____

ID# _____ Group # _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured _____ DOB _____ Relationship to Patient _____

Name of Employer _____

## FOR OFFICE USE ONLY INSURANCE VERIFICATION

Effective Date _____ Plan Type _____ Contract Year _____ Network: ☐ In ☐ Out

Co-pay _____ # of visits a year _____ Limits _____ Deductible _____ Met: _____

Out of Pocket: Max _____ Met _____ Precert: ☐ Yes ☐ No Referral: ☐ Yes ☐ No Optum pre auth: ☐ Yes ☐ No

DX Codes

| DX Codes: 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| | | | | | |

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## HEALTH INFORMATION

Main complaint _____

How bad? _____ How often? _____

When did it start? _____

Getting worse? _____ Getting better? _____

Please explain _____

Is your condition due to an accident? ☐ Yes ☐ No If yes, accident date _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

What activity bothers it the most? _____

When is it at its best? _____ When is it at its worst? _____

Rate the pain (0 is pain free, 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Have you seen other physicians for this problem? _____

## HEALTH HISTORY Check all that apply.

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Breast Lump | ☐ Tonsillitis | ☐ Glaucoma | ☐ Herpes | ☐ Migraines | ☐ Parkinson's |
| ☐ Thyroid | ☐ Allergies | ☐ Bronchitis | ☐ Depression | ☐ Goiter | ☐ Hepatitis | ☐ Miscarriage |
| ☐ Pneumonia | ☐ TB | ☐ Anemia | ☐ Bulimia | ☐ Diabetes | ☐ Gonorrhea | ☐ Mono |
| ☐ Prostate | ☐ Tumors | ☐ Anorexia | ☐ Cancer | ☐ Gout | ☐ Emphysema | ☐ Implants |
| ☐ M.S. | ☐ Prosthesis | ☐ Ulcers | ☐ Cataracts | ☐ Epilepsy | ☐ Heart Disease | ☐ Measles |
| ☐ Mumps | ☐ Arthritis | ☐ Chicken Pox | ☐ Hernia | ☐ Liver Disease | | ☐ Osteoporosis |
| ☐ Stroke | ☐ Asthma | ☐ Cholesterol | ☐ Fractures | ☐ Pacemaker | ☐ Appendicitis | ☐ Fibromyalgia |
| ☐ Chronic Fatigue | | ☐ Herniated Disc | | ☐ Kidney Disease | | ☐ Blood Pressure |
| ☐ Rheumatoid Arthritis | | ☐ Whooping Cough | | ☐ Other, if not listed: _____ | | |

What kind of exercise do you do: _____

Women: How many children? _____ Nursing? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No

Previous surgeries & dates _____

List all medications you are currently taking _____