



# WELCOME!

Thank you for choosing Greater Portland Chiropractic.

Please complete both sides of this form and return it to the receptionist when it is complete.

If you have any questions, please do not hesitate to ask.

## Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Hm. Address: \_\_\_\_\_

Hm. Phone: \_\_\_\_\_

Sex:  M  F      Age: \_\_\_\_\_      Birthdate: \_\_\_\_\_

Single       Married       Widowed       Separated       Divorced

Patient SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Em. Addr.: \_\_\_\_\_

Work Phone: \_\_\_\_\_      Ext.: \_\_\_\_\_

Best time and place to reach you: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_      SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

**In case of emergency, contact:**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Payment Information

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Check One:     Cash       Insurance (please complete the following)

Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_      Group #: \_\_\_\_\_

Is there a secondary insurance?     Y     N

If yes, please complete the following:

Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_      Group #: \_\_\_\_\_

### ALL INSURANCE PATIENTS PLEASE READ AND SIGN ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above Insurance company and assign directly to Dr. Kenneth Cayer 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 Greater Portland Chiropractic 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

\_\_\_\_\_

Date

## Accident Information

Is this condition due to an accident?     Y     N

Type of accident:  Auto     Work     Home     Other

To whom have you made a report of your accident? (check all that apply)

Auto Ins.     Employer     Worker Comp     Other \_\_\_\_\_

Attorney: \_\_\_\_\_

Contact #: \_\_\_\_\_

## Patient Condition

Reason For Visit: \_\_\_\_\_

When Did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

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

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp     Dull     Throbbing     Numbness     Aching     Shooting

Burning     Tingling     Cramps     Stiffness     Swelling     Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your     Work     Sleep     Daily Routine     Recreation

Activities or movements that are painful to perform:     Sitting     Standing     Walking     Bending     Lying Down     Other \_\_\_\_\_



