

Registration & History Form

PATIENT INFORMATION

Date: _____

Patient Name: (Last Name) _____

First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Sex: M F DOB: _____ Age: _____

Married Single Widowed Divorced

Separated Minor Partnered for _____ years

Occupation: _____

Employer Name: _____

Address: _____

Employer Phone: (____) _____

Spouse's Full Name: _____

Spouse's DOB: _____

Spouse's Employer Name: _____

Whom may we Thank for referring you?

Drive by (Sign) Yellow Pages Website

Booth; Where? _____

PPO Directory Doctor; Name: _____

Patient; Name: _____

PHONE NUMBERS

H: (____) _____ C: (____) _____

Emergency Contact:

Name: _____ Relationship: _____

H: (____) _____ C: (____) _____

PATIENT CONDITION

Reason for visit: _____

When did symptoms appear (Begin)? _____

Is this condition getting worse? Yes No Unknown

Rate the intensity of your pain on a scale from 1 (least pain) to 10 (worse pain) _____

Type of pain: (Check all that apply)

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? Constant Comes and goes

Does it interfere with your Work Sleep Daily routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending

INSURANCE INFORMATION

Insured Name: _____

Relationship to patient: _____

Insurance Carrier: _____

ID#: _____

Group#: _____

Insured's DOB: _____

Is patient covered by additional insurance?

Yes No

If yes; Insured Name: _____

Relationship to patient: _____

Insurance Carrier: _____

ID#: _____

Group#: _____

Insured's DOB: _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (carrier), And assign benefits directly to Dr. Jawad and Total Health & Wellness Center. I understand that I am responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining related insurance benefits. This consent will end when my treatment is complete at this office.

Patient Signature, or Guardian

Print Name

Date

Relationship to patient