Chiropractic Registration

Date: _____

Name: _____
First Middle Last

Nickname: _____

Address: _____

_____
City State Zip Code

Social Security #: _____

Marital Status: (Circle One) Married Single Widowed Divorced Separated

Patient's Date of Birth: _____ Age: _____

Phone #'s: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Occupation: _____ Employer: _____

Spouse's Name: _____

Emergency Contact

Name: _____ Relationship: _____

Phone #'s: Home: _____ Work: _____ Cell: _____

Referral Information

Who may we thank for your referral? _____

How did you find our phone number? (Circle One) Insurance Directory Phonebook

Internet Search Friend drwinger.com Other (Please Specify) _____

Insurance Filing / Collection Policy

I certify that I, and / or my dependant(s), assign insurance coverage benefits directly to Winger Chiropractic, PC. I understand that I am financially responsible for all charges incurred. I authorize the use of my signature on all insurance submissions.

Winger Chiropractic, PC may use my personal health information for the purpose of obtaining payment for services rendered and determining insurance benefits or the benefits payable for related services.

The undersigned agrees that in the event that this account is turned over for collection to a third party, he/she will be responsible for the costs of collection which include, but are not limited to, collection agency fees, reasonable attorney's fees, court costs and pre-judgment interest at the statutory rate.

_____
Signature of Patient, Parent, Guardian, or Personal Representative Date

Health History

What treatments have you already received for your condition?
Please circle all that apply: Medication Surgery Physical Therapy Chiropractic Care
Other (Please Specify) _____
Name of doctor(s) who have treated your condition: _____
_____
Name of your primary doctor: _____
May we share information with the above doctors? (Yes or No) _____

Please circle if you have or have had any of the following:

Stroke	Chicken Pox	Liver Disease	Scarlet Fever
Cancer	Eating Disorders	Measles	Suicide Attempt
Heart Disease	Emphysema	Migraine Headaches	Thyroid Problems
Diabetes	Epilepsy	Miscarriage	Tonsillitis
Pacemaker	Fractures	Multiple Sclerosis	Tuberculosis
Alcoholism	Glaucoma	Mumps	Tumors, Growths
Allergy Shots	Goiter	Osteoporosis	Typhoid Fever
Anemia	Gonorrhea	Parkinson's disease	Ulcers
Appendicitis	Gout	Pinched Nerve	Vaginal Infections
Arthritis	Hepatitis	Pneumonia	Venereal Disease
Bleeding Disorders	Hernia	Polio	Whooping Cough
Breast Lump	Herniated Disc	Prostate Problem	Other: _____
Bronchitis	Herpes	Prosthesis	_____
Cataracts	High Cholesterol	Psychiatric Care	_____
Chemical	HIV/Aids	Rheumatoid Arthritis	_____
Dependency	Kidney Disease	Rheumatic Fever	_____

Are you pregnant? (Please Circle One) Yes No Maybe **Due Date:** _____

Past Injuries (Falls, Fractures, Dislocations) / Surgeries / Hospitalizations:

Description:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Exercise: (Circle One) None Light Moderate Heavy **# of times per week** _____

Work Activities: (Circle All That Apply) Sitting Standing Light Labor Heavy Labor

Habits: (Circle All That Apply) Smoking Chewing Tobacco Alcohol Caffeine

List of Medications or Supplements: _____
_____
_____
_____

Allergies: _____