Geneva Spinal Health

Registration & History

Patient Information

Patient Name: _____
Address_____
_____
City State Zip
Sex: Male☐ Female☐
Age: _____
Birth date: _____
Marital Status: ☐Single ☐Married ☐Widowed
☐Separated ☐Divorced
Patient SS#_____
Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____
Spouse's Name: _____
Spouse Birth date: _____
Spouse SS#_____
Occupation: _____
Employer: _____
How did you hear about Geneva Spinal Health?
_____
E-Mail Address_____

Insurance Information

Who is responsible for this account? _____
Relationship to Patient_____
Insurance Co._____
ID # _____ GR # _____
SS# _____
Subscribers Name _____
Birthday _____
Additional Insurance Yes☐ No☐
Relationship to Patient _____
SS# _____
Insurance Co._____
ID # _____ GR # _____

Assignment and Release

I, the undersigned certify that I(or my dependent) have insurance coverage with _____ and assign directly to Geneva Spinal Health and Pain Management 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 herby authorize the doctor 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

_____ _____
Relationship Date

Phone Numbers

Home: _____
Work: _____
Cell: _____
In case of emergency contact
Name: _____
Relationship: _____
Home: _____
Work: _____
Cell:

Accident Information

Is this condition due to an accident ☐Yes ☐No Date _____

Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Worker Comp. ☐Police ☐Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit_____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐Yes ☐No ☐ Unknown
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10
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? ☐Daily ☐Weekly ☐Once in a while
Is the pain constant or does the pain come and go.
Does it interfere with ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____
Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down
Treatment you have received for your condition? ☐Medical ☐Physical Therapy ☐Chiropractic ☐None ☐Other
Name and address of the other doctor(s) who have treated you for your condition_____
_____

Geneva Spinal Health

Primary Care Physician: _____ Date Last Seen: _____
Address_____
_____ Phone: _____

Past Medical History

AIDS/HIV	☐Yes ☐No	Emphysema	☐Yes ☐No	Miscarriage	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Alcoholism	☐Yes ☐No	Epilepsy	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Fractures	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No	Mumps	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Anorexia	☐Yes ☐No	Goiter	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Appendicitis	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Pancreatic	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Asthma	☐Yes ☐No	Headaches	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Heart Disease	☐Yes ☐No	Pinched Nerve	☐Yes ☐No	Ulcers	☐Yes ☐No
Breast Lump	☐Yes ☐No	Hepatitis	☐Yes ☐No	Pneumonia	☐Yes ☐No	Urinary Tract Infections	☐Yes ☐No
Bronchitis	☐Yes ☐No	Hernia	☐Yes ☐No	Polio	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Bulimia	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Prostate Problem	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Cancer	☐Yes ☐No	Herpes	☐Yes ☐No	Prosthesis	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Cataracts	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Other_____	
Chemical Dependency	☐Yes ☐No	High Blood Cholesterol	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No		
Chicken Pox	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No		
Depression/ Anxiety	☐Yes ☐No	Liver Disease	☐Yes ☐No				
Diabetes	☐Yes ☐No	Measles	☐Yes ☐No				

Exercise
☐none
☐moderate
☐Daily
☐Heavy

Work Activity
☐Sitting
☐Standing
☐Light Labor
☐Heavy Labor

Habits
☐Smoking Packs/Day_____
☐Alcohol Drinks/Week_____
☐Coffee/Caffeine Drinks Cups/Day_____
☐High Stress Level Reason_____

Are you pregnant? ☐Yes ☐No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Allergies

Vitamins/Herbs/Minerals

Family History

Have your immediate family members (mother, father, sister, brother, grandparents) had any of the following:

☐High Blood Pressure
☐Heart Disease
☐Emphysema
☐Seizures-Convulsions
☐HIV Positive
☐Asthma
☐Diabetes
☐Kidney Disease
☐Back Problems
☐Ulcer or Stomach Problems
☐Stroke
☐Arthritis-Rheumatism
☐Mental Illness
☐Headaches
☐Thyroid Disease
☐Circulation Problems
☐Cancer
☐Osteoporosis
☐Other
Explain: