

Patient Registration & Information

Patient Information

Date of Birth _____ Age _____

SSN / ID _____

Address _____

Home Phone _____

Other Phone _____

Email Address _____

Marital Status _____ # of Children _____

Occupation _____

Employer Name _____

Address _____

Employer Phone _____

Primary Care Physician _____

Have you seen other doctors about this complaint?
 No Yes Name: _____
not
 Closest relative living with you _____

Phone _____

In case of emergency, contact _____

Phone _____

Whom may we thank for referring you?

Name _____

File # _____ Date _____

Insurance Information

Name of Insured _____

Relationship to Patient _____

Insured Date of Birth _____

Check here if copy of card is on file

Is there a secondary policy? Y N

Name of Secondary Insured: _____

Relationship to Patient _____

Insured Date of Birth _____

Check here if copy of card is on file

Accident Information

Is this condition related to an accident?
 No Yes Date: _____

Type of Accident Auto Work Other

To whom have you reported your accident?
 Auto insurance Employer Other

Attorney Name: _____

Patient Condition

Reason for visit _____

When did symptoms appear? _____ How often do you have this pain? _____

Is condition getting progressively worse? No Yes Is it constant or does it come and go? _____

Does your pain interfere with your Work Sleep Daily routine Recreation

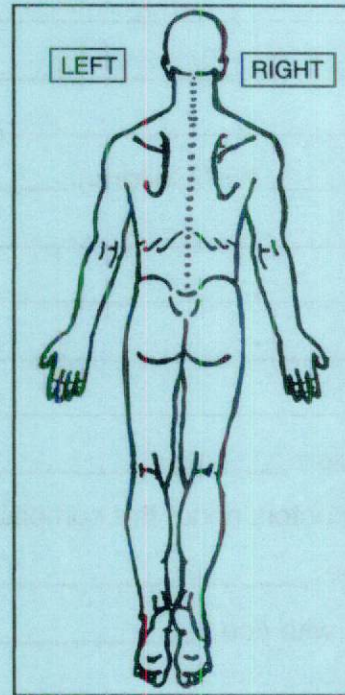
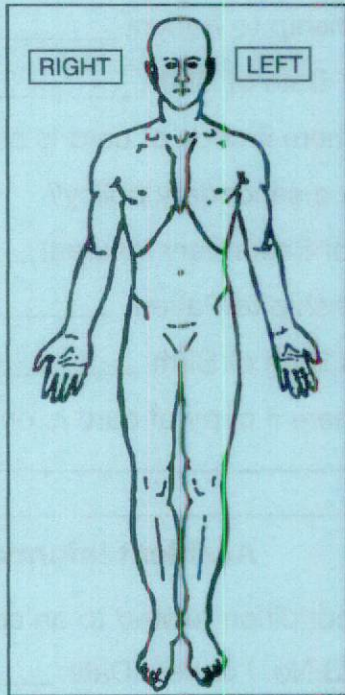
Activities/movements that are painful to perform: Sitting Standing Walking Bending Lying

PATIENT CONDITION, Continued

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

Type of pain:

- | | | | |
|-----------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramps | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Aching | <input type="checkbox"/> Other |



The information contained on both sides of this form is correct and complete to the best of my knowledge. I hereby give Dr. Richart and his staff permission to examine and treat my condition(s). I understand it is my responsibility to inform my doctor of any changes in my health.

Patient Signature: _____ Date: _____