

TROY NEUROPATHY CENTER

Dr. Anthony Paternoster • 1767 West Big Beaver Road • Troy, MI 48084

Welcome To Our Office

Thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Marital Status: _____ Sex: M F Number of Children: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

E-mail Address: _____

If referred, who can we thank for referring you to our office? _____

PHONE NUMBERS

Home Phone: (_____) _____

IN CASE OF EMERGENCY CONTACT:

Work Phone: (_____) _____

Name: _____

Cell Phone: (_____) _____

Relationship: _____

Best Time and Place To Reach You Is: _____

Home Phone: _____

Cell Phone: (_____) _____

INSURANCE INFORMATION

Do you have health care insurance? Yes No Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Relationship to Patient: _____

Is patient covered by additional insurance? Yes No If yes, please complete the following:

Insurance Company: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

Are you here due to an: auto accident on the job injury other accident: _____

If so, please complete the following: Date of accident: _____

To whom have you reported the accident: Auto Insurance Workers Comp. Other

Insurance Company: _____ Claim Number: _____

HEALTH HISTORY

Have you had previous chiropractic care? Yes No If yes, where: _____

When was your last adjustment? _____ Could you be pregnant? Yes No

What are your major/primary complaints?

How long have they been bothering you?

1) _____

1) _____

2) _____

2) _____

Have you ever had any falls, auto accidents, or injuries? Yes No If yes, please describe:

Month/Year _____ Type of Accident _____ Describe Injury _____

Month/Year _____ Type of Accident _____ Describe Injury _____

Have you ever had surgery? Yes No If yes, please describe:

Month/Year _____ Type of Surgery _____ Comments _____

Month/Year _____ Type of Surgery _____ Comments _____

Are you currently taking medication or vitamins? Yes No If yes, please list:

Name _____ Does per day _____ For how long _____

Name _____ Does per day _____ For how long _____

Please check any of the following that you have experienced within the last 6 months:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS / HIV positive | <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Prostrate trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of smell or taste | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Grinding in the neck | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Shooting head pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hernia | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Swollen ankles/joints |
| <input type="checkbox"/> Cold hands/fingers | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Pain in shoulders/arms | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Cold feet/toes | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Tightness in shoulders/arms |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Painful joints | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Pins & needles in arms/hands | <input type="checkbox"/> Twitching of face |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pins & needles in legs/feet | <input type="checkbox"/> Ulcers |

Do you drink alcohol? Yes No How often: _____ Do you smoke? Yes No How often: _____

AUTHORIZATION

Assignment/Release of Information: I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office or professional, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office. I authorize this office to release any information pertinent to my case to any insurance company, adjustor, and/or attorney involved in this case.

Signature: _____ **Date:** _____

Financial Responsibility: I agree to be financially responsible for all my charges incurred at this office including deductible, co-payment and any services rejected by my insurance company.

Signature: _____ **Date:** _____