TROY NEUROPATHY & CHIROPRACTIC 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: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Best way to reach you for appointment reminder:

Phone Call ☐ Text Message ☐

IN CASE OF EMERGENCY CONTACT:

Name: _____

Relationship: _____

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:

To whom have you reported the accident:

Insurance Company: _____

Date of accident: _____

☐ Auto Insurance ☐ Workers Comp. ☐ Other

Claim Number: _____

HEALTH HISTORY

Have you had previous chiropractic care? ☐ Yes ☐ No When was your last adjustment? _____

For Female Patients: Could you be pregnant? ☐ Yes ☐ No ☐ N/A

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:

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