WELCOME!

Thank you for allowing my staff and me to become part of your health care team.
Please provide us with the information necessary to establish your personal file in this office.
If you should have any immediate questions, do not hesitate to ask!

Sincerely,
Rick Trevisin, D.C.

PATIENT INFORMATION

Date _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. _____
FIRST MIDDLE LAST

Home Address _____
STREET CITY ZIP

Birth Date _____ Social Security # _____

Home Phone _____ Cell Phone # _____

Email Address _____

Patient Employed By _____ Occupation _____

Business Address _____

Name of Spouse _____ Spouse's Employer _____

Referred By _____

Purpose of this Appointment _____

Date of Onset _____ Was this an accident? _____ ☐ Auto ☐ Work ☐ Other

Please describe the circumstances _____

_____

Prior Surgery _____

_____

Medications Currently Taken _____

_____

INSURANCE INFORMATION

Today, many health insurance companies require verification or pre-authorization of coverage at the time of your first visit. Please provide us with the following so we may assist with the filing of any claims on your behalf.

Do you have Medicare? ☐ Yes ☐ No Medicare #_____

First Insurance Co. _____ Group #_____

Insured's I.D. #_____ ☐ Beneficiary ☐ Dependent

Have you met this year's deductible? ☐ Yes ☐ No ☐ Not Sure

Please provide us with your Medicare/Insurance Card so we may place a copy in your personal file.

(OVER)

PERSONAL HEALTH QUESTIONNAIRE

Please indicate with a check mark any areas that are currently bothering you, or have been a significant problem in the past.

MUSCULOSKELETAL SYSTEM

- ☐ Headaches
- ☐ Neck Pain
- ☐ Arm Pain / Numbness
- ☐ Pain between the Shoulders
- ☐ Mid-back Pain
- ☐ Low Back Pain
- ☐ Leg Pain / Numbness
- ☐ Swollen Joints
- ☐ Stiff Painful Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Broken Bones

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Paralysis
- ☐ Dizziness / Vertigo
- ☐ Fainting
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Depression

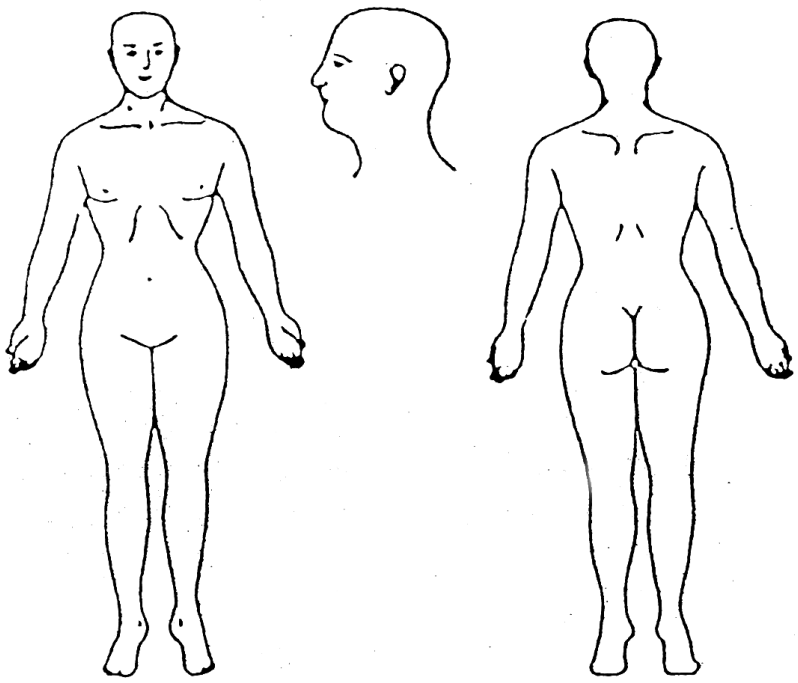
FEMALE

- ☐ Breast Pain
- ☐ Lumps in Breast
- ☐ Vaginal Pain
- ☐ Pregnant / May Be

CARDIOVASCULAR – RESPIRATORY

- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ C.V.A. / Stroke
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ T.I.A.s
- ☐ Aneurysm
- ☐ Pacemaker - Defibrillator

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



GASTROINTESTINAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive Hunger
- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Problems

EYE-EAR-NOSE-THROAT

- ☐ Vision Problems
- ☐ Eye Inflammation
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Ear Discharge
- ☐ Hearing Losss
- ☐ Nose Pain
- ☐ Excessive Discharge
- ☐ Sore Mouth or Gums
- ☐ Jaw Pain or Clicking
- ☐ Grind Teeth
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Difficult Speech

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand any services rendered are with my consent and approval.

Signature _____