Benessere Chiropractic, Massage and Fitness, LLC

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Patient Registration

Today's Date_____

Name_____ Date of Birth _____
Address_____ Home Phone_____
City_____State____Zip_____ Cell Phone_____
Social Security #_____ Work Phone_____
Employer_____Occupation_____ email_____
M__ F__ Preferred Gender designation: _____
Marital Status: S M W D P Spouse's Name_____ # of children_____
How did you hear about us? _____
Emergency contact:_____ Phone:_____
I am here today due to: __Illness __Trauma __Work Injury __Auto Crash __Other
Date of the injury? _____

Personal Insurance Company: _____
Name of Insured:_____ ID No: _____
Group No:_____ Claim No:_____ Medicare No: _____
Secondary Insurance Company:_____
Name of Insured:_____ ID No: _____
Group No: _____ Claim No: _____ Medicare No: _____

Agreement

I understand that my Insurance policy is a contract between my insurance carrier and myself. Benessere Chiropractic, Massage and Fitless, LLC (Benessere) will bill my Insurance Company as a courtesy and does not guarantee payment by my Insurance Company. I agree that I am personally responsible for all the services rendered to me by the practitioners at Benessere.
I authorize the release of any prior medical information necessary to be properly evaluated by Chiropractors at Benessere and to assist in the processing of my insurance claim. I authorize my Insurance Company to send payments for services rendered directly to Benessere.

Patient Signature: _____ Date: _____

First Priority for Treatment

Body region: _____

When did symptoms first start? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom in the past: [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time before in your life:

Where? _____
When? _____
Response to prior treatment: _____
Type of prior treatment: _____

Additional information: _____
_____

Second Priority for Treatment

Body region: _____

When did symptoms first start? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom in the past: [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time before in your life:

Where? _____
When? _____
Response to prior treatment: _____
Type of prior treatment: _____

Additional information: _____
_____

Third Priority for Treatment

Body region: _____

When did symptoms first start? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom in the past: [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time before in your life:

Where? _____
When? _____
Response to prior treatment: _____
Type of prior treatment: _____

Additional information: _____
_____

Past Health History

Have you ever been under Chiropractic care? [ ] No [ ] Yes (names):

_____

Reason for treatment: _____

Response to treatment: _____

Techniques used: _____

Do you take vitamins or minerals? [ ] No [ ] Yes

Please list:_____

Please list all medications: _____

Have you had any X-Ray, MRI, CT scans in the past 10 years? [ ] No [ ] Yes

Date	Test	Body Region	Doctor/Testing Center
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever broken/fractured a bone?

Date:	Bone/Region:	Treatment	Completely Healed?
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Have you ever been involved in a prior car crash?

Date:	Description:	Injuries:	Resolved:
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Please list all surgeries or major illnesses.

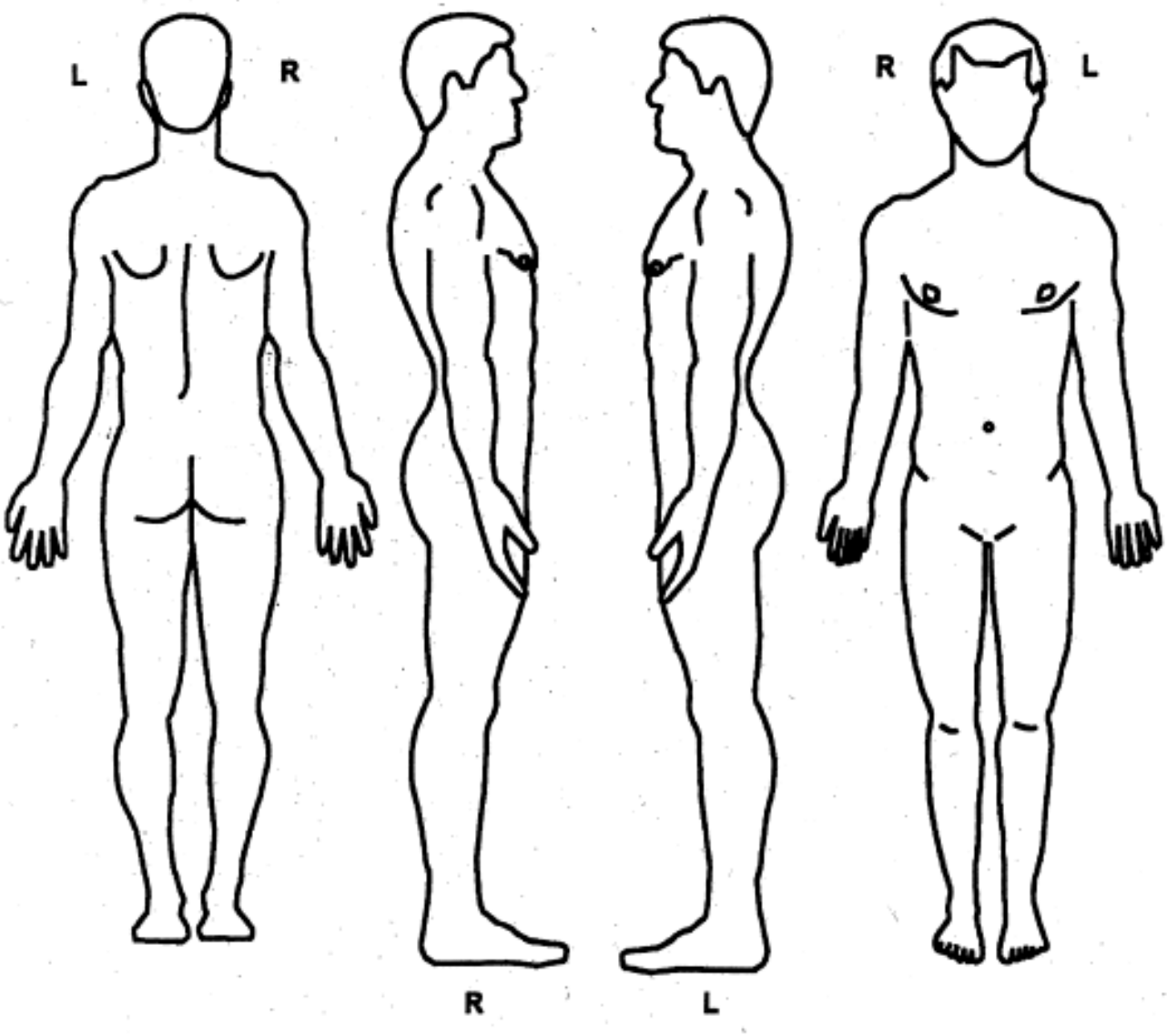
Date:	Description:	Resolved:
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

Other injuries (falls, concussions, trauma):

Date:	Description:	Resolved:
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

	Heavy	Moderate	Light	None	Do you wear?
Alcohol	[ ]	[ ]	[ ]	[ ]	[ ] Orthotics
Tobacco	[ ]	[ ]	[ ]	[ ]	[ ] Heel lifts
Coffee	[ ]	[ ]	[ ]	[ ]	[ ] Insoles
Exercise	[ ]	[ ]	[ ]	[ ]	[ ] Arch supports
Sleep	[ ]	[ ]	[ ]	[ ]	

Pain Drawing



Mark as follows:
A = Ache B = Burning N = Numbness P = Pins & Needles / Tingle S = Stabbing
O = Other, describe _____

Payment Policy

We require payment at the time of service. If you have private health insurance we ask that you pay your co-pay or co-insurance at the time of service. If you have a yearly deductible, you must meet that as your policy specifies. We may or may not bill, or you may bill, your insurance company. If payment for any part of your treatment is denied by your insurance carrier you will assume full responsibility for payment and will pay independent of any appeal process with the insurance carrier.

In the case of either personal injury, auto accident, or workers' compensation claims, we will bill the entire amount of each visit to your insurance company. The cost of supplies, supports and/or supplements not paid for by your insurance company is your responsibility.

If you have any questions concerning our payment policy, please feel free to ask the receptionist.

Cancellation Policy

We require 24 hours notice for all cancellations. If you cancel with less than 24 hours notice, you will be charged 50% of the total charges for the scheduled visit. If you fail to attend your appointment and do not call to cancel, you will be charge IN FULL for the total visit. We send reminder texts as a courtesy. It is your responsibility to be on time for your appointments.

I have read and understood the above payment and cancellation policies and agree to follow them while utilizing the services at Benessere Chiropractic Massage and Fitness, LLC.

Signed_____ Date_____