REGISTRATION

Patient: _____ Date: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: □ M □ F Age: ____ Birthdate: _____ Phone: _____

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

ASSIGNMENT AND RELEASE

Patient Agreement: I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to John Carlucci, D.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle)

Headache	Bleeding / fluid from ears or nose	Neck pain
Mental dullness	Depression / emotional	Upper back pain
Loss of memory	Ribs, chest pain	Lower back pain
Dizzy	Nervousness	Weight gain or loss
Ears ringing / buzzing	Eye strain / pain	Weakness
Blurred / double vision	Shortness of breath	Loss of smell
Fainting / black outs	Slurred speech	Chest pain
Unbalanced	Confusion	Hands / feet cold
Pain, tingling or numbness in hands right / left	Pain, tingling or numbness in arms right / left	Pain, tingling or numbness in legs right / left

Have any of the above appeared SUDDENLY?

Medical Implants: _____ **Medical alerts: _____**
Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: _____ Date: _____

Medications / Supplements: *(please list all that you currently take)*

_____

_____

Allergies: *(include all **medications** that cause allergic reaction)*

_____

_____

Smoking: ___ Yes ___ No If yes, _____ Packs per day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

_____

_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma
□ COPD
□ emphysema
□ pulmonary embolism
□ pneumonia
□ tuberculosis
□ respiratory arrest
□ sleep apnea
□ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina
□ heart attack
□ congestive heart failure
□ other: _____
□ high blood pressure
□ heart murmur, valve disorder
□ mitral valve prolapse
□ irregular heartbeat, arrhythmia
□ peripheral vascular disease
□ deep vein thrombosis
□ bleeding problems

Neurologic Disorders

□ stroke or TIA
□ peripheral neuropathy
□ other: _____
□ Parkinson's
□ MS
□ cerebral palsy
□ polio

Bone & Joint Disorders

□ osteoarthritis
□ rheumatoid arthritis
□ other: _____
□ gout
□ lupus
□ osteomyelitis
□ ankylosing spondylitis

Patient Name: _____ Date: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer of any type -- please specify
_____

Other medical problems NOT included above (explain)
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems
□ MS or Parkinson's □ Peripheral neuropathy □ other neurological _____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease
□ liver disease □ other GI :_____ □ hepatitis - Type _____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer of any type, please specify: _____

Other medical problems NOT included above (explain): _____

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Comp	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address:

_____

_____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

Patient Name: _____ Date: _____