WELCOME

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ❑ M ❑ F
Social Security Number _____
Birthdate _____ Age _____
❑ Married ❑ Single ❑ Minor
Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone (___) _____

Spouse Name _____
Phone # _____
Birthdate _____
Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co _____
Member Id # _____
Group # _____
Is patient covered by additional insurance? ❑ Yes ❑No
Subscriber's Name_____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Member Id # _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company
Dr. Michelangelo Rubino D.C. all insurance 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 authorize the use of my signature on all insurance submissions.
Dr. Michelangelo Rubino D.C. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative.

_____
Print name of Patient, Parent, Guardian or Personal Representative.

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____-_____
Cell Phone (____) _____-_____
Best time and phone to call you _____

Emergency Contact

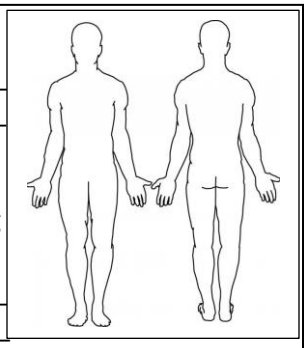
Name _____
Relationship _____
Home Phone (____) _____-_____
Cell Phone (____) _____-_____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No
Date _____
Type of Accident ❑ Auto ❑ Work ❑ Home ❑ Other
To whom have you made a report of your accident?
❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other
Attorney Name (if applicable)

_____

PATIENT CONDITION



Reason for visit _____
When did your symptoms appear? _____
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other
How often do you have this pain? _____
Is it constant of does it come and go? _____
Does it interfere with; ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Activities of movements that are painful to perform; ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

VITA CHIROPRACTIC

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
		AIDS/HIV			Diabetes			Liver Disease			Rheumatic Fever
		Alcoholism			Emphysema			Measles			Scarlet Fever
		Allergy Shots			Epilepsy			Migraines			Sexually Transmitted
		Anemia			Fractures			Miscarriage			Diseases
		Anorexia			Glaucoma			Mononucleosis			Stroke
		Appendicitis			Goiter			Multiple Sclerosis			Suicide Attempt
		Arthritis			Gonorrhea			Mumps			Thyroid Problems
		Asthma			Gout			Osteoporosis			Tonsillitis
		Bleeding Dissorders			Heart Disease			Pacemaker			Tuberculosis
		Breast Lump			Hepatitis			Parkinson's			Tumors/Growths
		Bronchitis			Hernia			Pinched Nerve			Typhoid Fever
		Bulimia			Herniated Disc			Pneumonia			Ulcers
		Cancer			Herpes			Polio			Vaginal Infections
		Cataracts			High Blood Pressure			Prostate Problems			Whooping Cough
		Chemical Dependency			High Cholesterol			Psychiatric Care			Other _____
		Chicken Pox			Kidney Disease			Rhuematoid Arthritis			_____

EXERCISE

❑ None
❑ Moderate
❑ Daily
❑ Heavy

Work Activity

❑ Sitting Hours/day _____
❑ Standing Hours/day _____
❑ Light Labor Hours/day _____
❑ Heavy Labor Hours/day _____

HABITS

❑ Smoking Packs/Day _____
❑ Alcohol Drinks/Week _____
❑ Coffee/Caffeine Cups/Day _____
❑ High Stress Levels Reason _____

Are you pregnant? ❑ Yes ❑ No Due Date _____

Injuries/Surgeries you have had:	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**HERBS / SUPPLEMENTS / VITAMINS**	**ALLERGIES**