# CONNER CHIROPRACTIC CARE

## CONFIDENTIAL NEW PATIENT REGISTRATION FORM

### PATIENT INFORMATION

****PLEASE FILL OUT THIS BOX ONLY IF PAYING CASH****

1. LAST NAME _____ 2. FIRST NAME _____ 3. MI _____
4. ADDRESS _____
5. CITY _____ 6. STATE _____ 7. ZIP_____
8. HOME (_____) _____ 9. WORK (_____)_____ 10. CELL (_____) _____
11. EMAIL _____ 12. AGE _____ 13. DATE OF BIRTH _____/_____/_____
14. SEX: ☐ M ☐ F 15. SOC. SEC.#_____-_____-_____ 16. MARITAL ☐ S ☐ M ☐ D ☐ W
17. SPOUSE'S NAME _____
18. PRIMARY CARE PHYSICIAN:_____ADDRESS:_____
TELEPHONE: (_____) _____ FAX: (_____) _____

### WORKERS COMPENSATION INFORMATION

1. EMPLOYER & OCCUPATION _____
2. ADDRESS _____
3. CITY _____ 4. STATE _____ 5. ZIP _____
6. BUSINESS PHONE # (_____) _____ 7. FAX # (_____)_____
8. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

### AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN/ATTORNEY ☐ _____
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY OCCURED? _____
_____
5. WHICH BODY PART(S) WERE INJURED? _____
6. NAME OF INS. CO. _____ 7. INS. PHONE (_____)_____
8. INS. CO. ADDRESS _____
9. POLICY # _____ 10. CLAIM # _____ 11. WCB # _____
12. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM?_____
13. HOSPITALIZED? ☐ NO ☐ YES WHERE?_____ 14. X-RAYS TAKEN ☐ NO ☐ YES BY WHOM _____
15. WERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES
16. ARE YOU PRESENTLY WORKING? ☐ NO ☐ YES IF NO, DATES LOST FROM WORK _____
17. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____
18. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐_____
19. # OF PEOPLE IN YOUR VEHICLE? _____ 20. WORE SEAT BELT? ☐ NO ☐ YES 21. DID AIRBAG INFLATE ☐ NO ☐YES
22. NAME OF ATTORNEY _____
ATTORNEY ADDRESS:_____
ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

### PRIVATE HEALTH INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. INSURED'S SS# _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
4. NAME OF INSURANCE CO. _____
5. ADDRESS _____
6. INSURANCE PH.# (_____)_____ 7. ID # _____ 8. GROUP# _____
**SECONDARY INSURANCE:** 9. INSURED'S NAME _____ 10. SS # _____/_____/_____
11. NAME IS INSURANCE CO. _____
12. ADDRESS _____
13. INSURANCE PH.# (_____)_____ 14. ID# _____ 15. GROUP# _____