

Beneski Chiropractic & Wellness Center
New Patient Registration Form

Patient Information:

Date _____ SS# _____
Patient Name _____
Address _____
City _____ State _____ Zip _____
Email _____
Sex Male Female Age _____ Birthdate _____
 Married Widowed Single Separated Divorced Minor
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone _____
Spouse's Name _____
Spouse's Birthdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Numbers:

Home Phone _____ Cell Phone _____
Best time and place to reach you _____
IN CASE OF AN EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone _____ Work Phone _____

Assignment and Release:

I, certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to Dr. _____ 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.

The above-named doctor 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative
Date _____ Relationship to Patient _____

Insurance Information:

Subscriber's Name _____ Date of Birth _____
Relationship to patient _____
Insurance company _____ Group # _____

Past Medical History:

Primary Care Physician _____
Address _____
Phone _____ Please do not contact my primary care physician
Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental Exam _____ MRI, CT-Scan, Bone Scan _____

Past Medical History-Continued

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

- | | | | | | |
|---------------------|--|--------------------|--|--------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chem. Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Other | _____ | | | | |

Are you pregnant? Yes No Due Date _____

Health History:

Habits:

- Smoking Packs/Day _____
- Alcohol Drinks/Week _____
- Coffee/Caffeine Cups/Day _____
- Diet _____
- Recent weight loss effort _____

Medications: None

Allergies: None

Vitamins/Herbs/Minerals: None

Family History:

Please list any family members that have past or present health conditions. (Heart disease, cancer, diabetes, stroke, arthritis etc.)

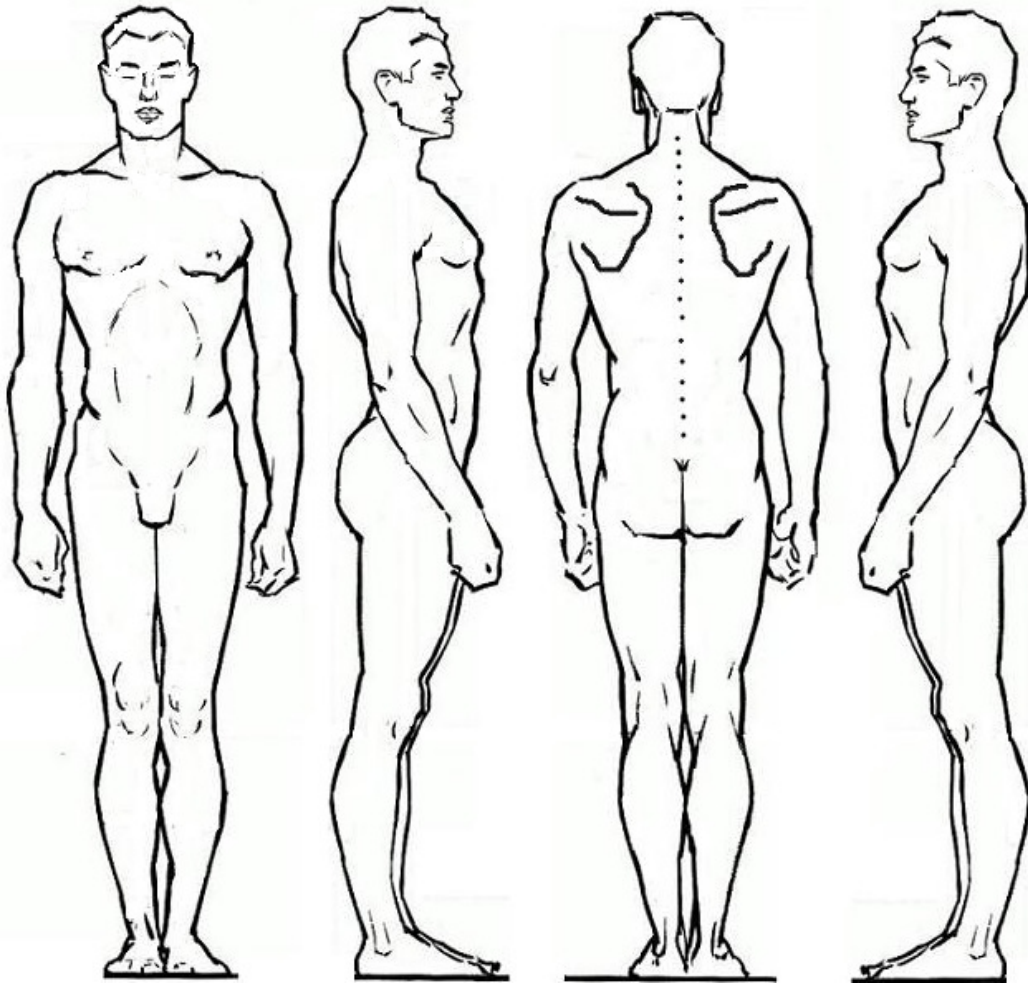
Website Access Registration:

Please sign below to receive access to our website for Patient Only Information and to provide permission to keep you up to date on office events, health information, and specials. You will also receive a free subscription to the Healthy Living Newsletter.

Signature: _____

MASSAGE:

Please Indicate Below any areas you are having trouble with: A=Ache, B=Burning, N=Numbness, P=Pins & Needles
S=Stabbing, O=Others



Use this space to mention any other issues or concerns:

Massage History:

Have you had professional massage before? _____ If so, when was your last one? _____

Do you get regular massage? _____ If so, how often? _____

MESSAGE CONSENT AND OFFICE POLICIES:

Consent for Care:

- It is my choice to receive Massage Therapy, and I give consent to receive treatment.
- I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders, and that Massage Therapy is not a substitute for medical examination and/or diagnosis.
- I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical and mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.
- I agree that If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- I understand that Massage is for Therapeutic purposes and no inappropriate sexual conduct will be tolerated.
- It is up to you and your therapist to discover the most beneficial firmness and pressure to be used. Communication is of utmost importance during this process. When working with your therapist let them know if something feels good and especially let them know if something is uncomfortable. With myofascial and deep tissue work there are times you can be uncomfortable and this would be a normal process.

Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Massage Appointment Policies:

- A 24 hour notice is required to cancel or reschedule massage appointments
- A "No Show" will be charged at the full price of the scheduled service
- Same day cancelled or rescheduled massages will be charged at 50% of the scheduled service
- If you held your appointment with a voucher and a 24 notice is not given, you will forfeit your voucher
- Late arrivals are not granted time extensions but will receive the remainder of their scheduled session and full session price will be due
- An appointment is held by payment for that appointment and payment is collected when an appointment is made. If an appointment is cancelled within 24 hours and a refund is requested it will be granted as soon as possible depending on payment type. Credit Card will be refunded immediately. Check or Cash will be refunded by check within 5 business days from request.

By signing below I acknowledge that I have read and understand the massage policies and that my credit card will be charged in the event that I do not give the required 24 hours notice to cancel or reschedule a massage appointment.

Client's Name (Printed): _____

Client's Signature: _____ Date: _____

Credit Card #: _____ Expiration: _____

Tipping:

- If you wish to tip your therapist for an exceptional job your generosity is appreciated. There are small manila envelopes at the front desk and in the massage room. Simply place your tip into the envelope and give it to the front desk. The envelope will remain closed and delivered to your therapist. Tipping is in no way mandatory!!!