Please Fill Out COMPLETELY. The more information we have, the better we can help you. Thank you.

Patient Registration – PERSONAL INJURY *(please print clearly)*

First Name _____ MI____ Last Name _____ Date___/___20___

Address _____ City _____ State _____ Zip _____

Date of Birth_____/_____/_____ Age _____ Social Security #_____-_____-_____

Drivers License #_____ State Issued _____

Email Address_____

Home Phone (____)-_____-_____ Cell Phone (____)-_____-_____ Work Phone (____)-_____-_____

Occupation_____ Employer _____

□ Married □ Single □ Domestic Partnership

Spouses Name: _____ # of Children_____

Occupation_____ Employer _____ Work # _____

Emergency Contact_____ Relationship_____ Phone:(____)_____-_____

Your Health Insurance Company _____ Phone Number (____)-_____-_____

Name of Insured: _____ Relationship to you: _____

ID # _____ Group # _____

Person Responsible for Charges_____ Phone # _____

Accident History

If involved in auto accident please complete the following:

Your Auto Insurance Carrier _____ Policy Number _____

Phone Number (_____) - _____ - _____

Do you have **Med**ical **Pay**ment Insurance: ☐ No ☐ Yes If yes, Amount $:_____

Other Party's Auto Insurance Carrier _____ Phone Number:_____

Claim Number _____

Do you have an Attorney: ☐ No ☐ Yes Name _____ Phone # _____

Please Describe Your Accident and Put a Check On Each Line That Applies

A. My accident happened on: ____/____/_____
B. I was in the: __driver's seat, __front passenger seat __ back seat on the __left __right.
C. The crash came from: ___behind ___ in front ___ left side ___ right side.
D. ____I was wearing my seatbelt. I was ___stopped ___moving.
E. ____I hit my head. ____I was unconscious. ____ I have memory loss.

F. Make and Model of car I was in _____ Year _____.
The estimate of damage to that car is $_____ The car was towed ☐ Yes ☐ No
G. Make and Model of the other car(s) involved _____
H. Was the other car citied for accident? ☐ Yes ☐ No ☐ Don't know
I. ☐ I went to the Emergency Room. ☐ I did not go to the Emergency Room.
☐ I was taken in an Ambulance. Which Hospital?_____
Did the Hospital take X-rays / CT / MRI? (circle images taken) ☐ No Images Taken
___ I did see other doctors or health care professionals since my crash.
J. Name of other Doctor/Clinic consulted since your accident _____

K. **Major Complaint** _____
L. ☐ I hit other parts of my body in this accident? _____

M. I had pain right away ☐ Yes ☐ No
N. Are your symptoms ☐ Improving? ☐ Getting Worse? ☐ Same? ☐ Other?_____
N. I missed work due to the accident ☐ Yes ☐ No How Many Days? _____

PLEASE EXPLAIN HOW YOUR ACCIDENT HAPPENED:_____
_____
_____
_____

Personal Health History

Allergies I have: _____

Please list hospitalizations and any surgeries that you may have had: Dates

_____

_____

List all medications you are currently taking:_____

Do you Smoke? ☐ Yes ☐ No If yes, how much per day?_____
Do you consume alcohol? ☐ Yes ☐ No If yes, what and how much per week? _____
What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy :_____

Has Anyone in Your Family Had These Health Problems?

__ Anemia	__ Stroke	__ Psychological Disorder	__ Glaucoma
__ Asthma	__ Epilepsy	__ Diabetes	__ Tuberculosis
__ Hay fever	__ Cancer	__Heart Disease	__ High Blood Pressure

Review of Symptoms

Height _____Weight _____ Weight 1 yr. Ago _____ Max. Weight _____ When _____

Please Circle ALL the letters that apply to each item:

Y= a condition you have now. **N**= a condition you never had.

Headache	Y	N	Bronchitis	Y	N
Neck Pain	Y	N	Pneumonia	Y	N
Mid Back Pain	Y	N	Emphysema	Y	N
Low Back Pain	Y	N	Difficulty Breathing	Y	N
Chest Pain	Y	N	Shortness of Breath	Y	N
(Please circle ALL that apply)			Heart Disease	Y	N
Right/Left Shoulder Pain/ Numb	Y	N	Angina	Y	N
Right/Left Arm Pain/Numb	Y	N	High Blood Pressure	Y	N
Right/LeftHand/WristPain/Numb	Y	N	Swollen Ankles/Stomach	Y	N
Right/Left Buttock Pain/Numb	Y	N	Hip/Joint Replacement	Y	N
Right/Left Thigh Pain/Tingling	Y	N	Nausea	Y	N
Right/Left Leg Pain/Tingling	Y	N	Vomiting	Y	N
Right/Left Foot/Toes Pain/Numb	Y	N	Constipation	Y	N
Spasms	Y	N	Blood in Stool	Y	N
Dizziness	Y	N	Gas/Bloating	Y	N
Blurry Vision	Y	N	Liver Disease	Y	N
Motion Restriction	Y	N	Hemorrhoids	Y	N
Trouble Sleeping	Y	N	Abdominal Pain	Y	N
Anxious/Fearful Driving	Y	N	Stomach Ulcer	Y	N
Night Sweats	Y	N	Gall Bladder	Y	N
Head Injury	Y	N	Painful Urination	Y	N
Impaired Vision	Y	N	Urinary Frequency	Y	N
Corrected Vision	Y	N	Ligament or Tendon repair	Y	N
Depression	Y	N	Kidney Stones	Y	N
Tearing/Dryness	Y	N	Blood in Urine	Y	N
Double Vision	Y	N	Joint Pain/Stiffness	Y	N
Jaw Pops/Clicks/Painful	Y	N	Arthritis	Y	N
Cataracts	Y	N	Broken Bones	Y	N
Impaired Hearing	Y	N	Muscle Spasms	Y	N
Ear Ringing	Y	N	Deep Leg Pain	Y	N
Earaches	Y	N	Blood Clots in Legs	Y	N
Frequent Colds	Y	N	Fainting	Y	N
Sinusitis	Y	N	Seizures	Y	N
Postnasal Drip	Y	N	Paralysis	Y	N
Change in Taste	Y	N	Muscle Weakness	Y	N
Thyroid Problems	Y	N	Numbness/Tingling	Y	N
Cough	Y	N	Coordination Difficulties	Y	N
Sputum	Y	N	Depression	Y	N
Spit up Blood	Y	N			
Asthma	Y	N	Anxiety	Y	N

Mood Swings	Y	N
Memory Loss	Y	N
Drug/Alcohol Abuse	Y	N
Afraid of Being in a Car	Y	N
Thyroid Problems	Y	N
Knee Surgery	Y	N
Excessive Thirst	Y	N
Excessive Hunger	Y	N
Anemia	Y	N
Easy Bleeding	Y	N

Are you HIV positive / AIDS?
YES____ NO____ Don't know___

Females Only

I am Pregnant _____ Yes _____ No
Due Date: _____
Age menses began _____
Age menses ended _____

Breast Lumps	Y	N
Painful Menses	Y	N
Sexual Difficulties	Y	N
Spotting	Y	N
Birth Control	Y	N
Irregular Cycles	Y	N

Average bleeding length _____
Average cycle length _____

Breast Pain	Y	N
Nipple Discharge	Y	N
Menopausal Symptoms	Y	N

Number of pregnancies _____
Number of live births _____
Number of miscarriages _____

Are there any additional health concerns or questions that you may have?

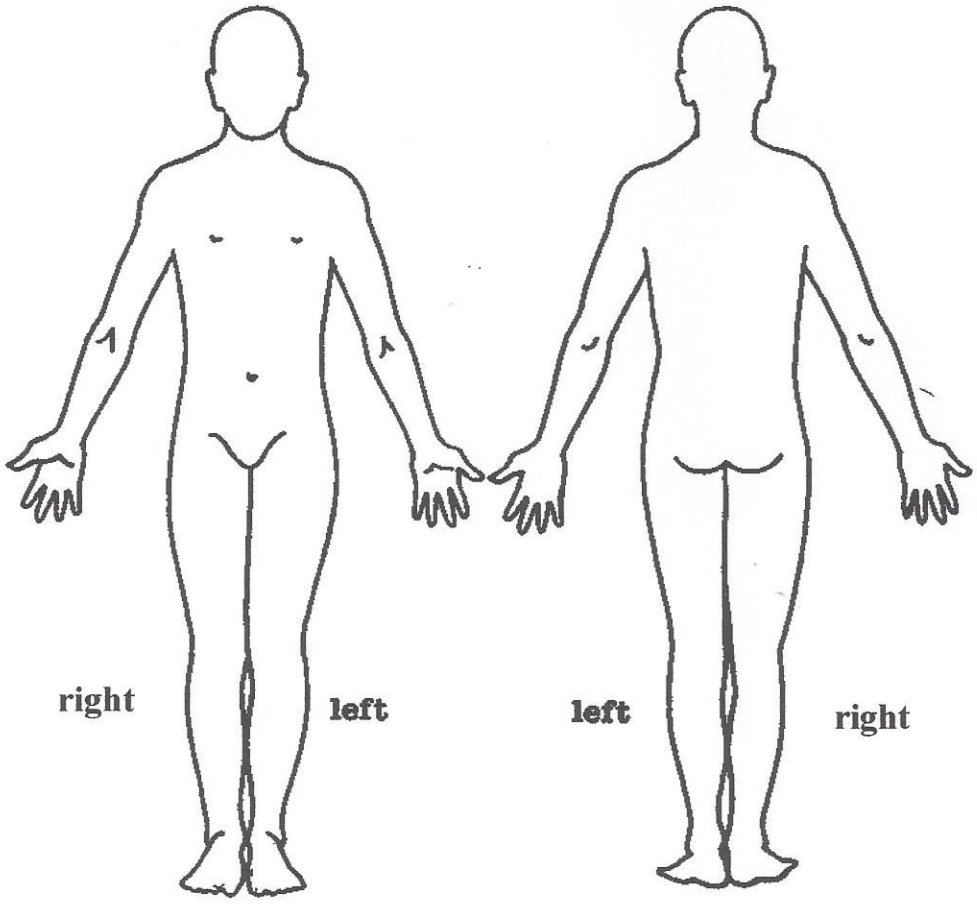
_____
_____
_____
_____
_____
_____

Numbness, Pins & Needles: **N**

Aching pain: **A**

Burning: **B**

Weakness: **W**



Please rate your discomfort on a scale of 1-10.

(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating
1.		
2.		
3.		

AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS AND ATTORNEY LEIN

This is an agreement between the undersigned patient and Comprehensive Medical Center.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Comprehensive Medical Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Comprehensive Medical Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care that my fees for professional services rendered to me by Comprehensive Medical Center will be immediately due and payable. *I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible which has not been met, co-pays or disallowed services.*

I hereby authorize Comprehensive Medical Center to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities. Original x-rays taken at Comprehensive Medical Center will remain the property of Comprehensive Medical Center, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Comprehensive Medical Center will not be held responsible for any pre-existing medically diagnosed conditions.

I authorize and direct the insurance company, and/or my attorney, *to pay directly to Comprehensive Medical Center* such sums as may be due and owing Comprehensive Medical Center for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Comprehensive Medical Center may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Comprehensive Medical Center the full amount of all services at their usual and customary fees notwithstanding any agreements Comprehensive Medical Center may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.
I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Comprehensive Medical Center my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ _____
Patient Name Person Authorizing Care if other than Patient

_____ ____/____/____
Signature **Date**

_____ ____/____/____
Witness Date

_____, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Comprehensive Medical Center.

_____ ____/____/____
Attorney's Name (Please Print) Date

_____
Attorney's Address

_____ _____
Attorney's Signature Attorney's Phone Number

HIPPA PRIVACY
AUTHORIZATION AND PERMISSION TO RELEASE HEALTH CARE INFORMATION

Please, **BE SPECIFIC** with names!

I, _____(patient's name) hereby authorize Comprehensive Wellness Center, LLC to use/or disclose my protected healthcare information to and/or from the following:

Parents: _____

Spouse: _____

Insured: _____

Other: _____

I have been given the opportunity to read the HIPPA regulations and understand its contents. I understand Comprehensive Wellness Center, LLC will use and/or disclose this information in attempt to provide my medical care and/or payment for services.

_____ **(Signature of Patient or authorized representative)**

_____ **(Relationship to Patient)**

_____ **(Date)**