DR. MATTHEW PAGANO
CHIROPRACTIC PHYSICIAN

one

WELCOME

ABOUT YOU

TODAY'S DATE: _____ FILE#: _____

NAME: _____

WHAT YOU PREFER TO BE CALLED: _____ ❑ MALE ❑ FEMALE

BIRTHDATE: ___/___/___ AGE: _____ SS#: _____

HOME ADDRESS: _____

_____
CITY STATE ZIP

HOME PHONE #: _____

OTHER PHONE #: _____

EMAIL ADDRESS: _____

REFERRED BY: _____

EMPLOYER: _____ HOW LONG? _____

EMPLOYER'S ADDRESS: _____

_____
CITY STATE ZIP

OCCUPATION: _____ WORK PHONE #: _____

MARTIAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED

SPOUSES'S NAME: _____

two

INSURANCE INFO

COMPLETE THIS BOX OR PROVIDE US WITH YOUR INSURANCE CARD

COMPANY NAME: _____

ADDRESS: _____

PHONE #: _____

INSURED'S SOCIAL SECURITY #: _____

GROUP # (PLAN, LOCAL OR POLICY#): _____

INSURED'S NAME: _____

RELATION: _____ DATE OF BIRTH: ___/___/___

INSURED'S EMPLOYER: _____

PLEASE INFORM FRONT DESK OF SECOND INSURANCE SOURCE.

REASON FOR VISIT

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE: ❑ YES ❑ NO

IF SO, PLEASE EXPLAIN: _____

THE REASON FOR THIS VISIT IS A RESULT OF: ❑ WORK ❑ SPORTS ❑ AUTO ❑ TRAUMA ❑ CHRONIC

EXPLAIN WHAT HAPPENED: _____

_____

PLEASE DESCRIBE THE PAIN & ITS LOCATION: _____

_____

WHEN DID THE CONDITION BEGIN? ___/___/_____

IS THIS CONDITION GETTING WORSE? ❑ YES ❑ NO ❑ CONSTANT ❑ COMES AND GOES

IS THIS CONDITION INTERFERING WITH YOUR ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE?

IF SO, PLEASE EXPLAIN: _____

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? ❑ YES ❑ NO

IF SO, PLEASE EXPLAIN: _____

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION? ❑ YES ❑ NO

IF SO, WHERE? _____

three

PLEASE CONTINUE ON BACK

DR. MATTHEW PAGANO
CHIROPRACTIC PHYSICIAN

IN EVENT OF EMERGENCY

WHO SHOULD WE CONTACT? _____

RELATION: _____

HOME PHONE #: _____

WORK PHONE #: _____

HEALTH HISTORY

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS:

❑ NERVE PILLS ❑ PAIN KILLERS (INCLUDING ASPIRIN) ❑ MUSCLE RELAXERS ❑ STIMULANTS

❑ BLOOD THINNERS ❑ TRANQUILIZERS ❑ INSULIN ❑ OTHER(S) _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES/MEDICAL CONDITION(S)?

❑ YES ❑ NO HEART ATTACK/STROKE	❑ YES ❑ NO HEART SURGERY/PACEMAKER	❑ YES ❑ NO HEART MURMUR
❑ YES ❑ NO CONGENITAL HEART DEFECT	❑ YES ❑ NO MITRAL VALVE PROLAPSE	❑ YES ❑ NO ARTIFICIAL VALVES
❑ YES ❑ NO ALCOHOL/DRUG ABUSE	❑ YES ❑ NO STD'S	❑ YES ❑ NO HEPATITIS
❑ YES ❑ NO HIV+/AIDS	❑ YES ❑ NO SHINGLES	❑ YES ❑ NO CANCER
❑ YES ❑ NO FREQUENT NECK PAIN	❑ YES ❑ NO EMPHYSEMA/GLAUCOMA	❑ YES ❑ NO ANEMIA
❑ YES ❑ NO HIGH/LOW BLOOD PRESSURE	❑ YES ❑ NO PSYCHIATRIC PROBLEMS	❑ YES ❑ NO RHEUMATIC FEVER
❑ YES ❑ NO SEVERE/FREQUENT HEADACHES	❑ YES ❑ NO KIDNEY PROBLEMS	❑ YES ❑ NO ULCERS/COLITIS
❑ YES ❑ NO FAINTING/SEIZURES/EPILEPSY	❑ YES ❑ NO SINUS PROBLEMS	❑ YES ❑ NO ASTHMA
❑ YES ❑ NO DIABETES/TUBERCULOSIS	❑ YES ❑ NO DIFFICULTY BREATHING	❑ YES ❑ NO CHEMOTHERAPY
❑ YES ❑ NO LOWER BACK PROBLEMS	❑ YES ❑ NO ARTIFICIAL BONES/JOINTS	❑ YES ❑ NO ARTHRITIS

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD: _____

_____

PLEASE LIST ANYTHING THAT YOU MAY BE ALLERGIC TO: _____

_____

LIST PREVIOUS SURGERIES/TREATMENTS WITH DATES: _____

_____

LIST ANY PAST SERIOUS ACCIDENTS WITH DATES: _____

LIST ANY MEDICATION(S) THAT YOU TAKING: _____

DO YOU SMOKE? ❑ YES ❑ NO HOW MUCH? _____ HOW LONG? _____

ARE YOU WEARING: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

WHAT IS THE AGE OF YOUR MATTRESS? _____ IS IT COMFORTABLE? ❑ YES ❑ NO

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO

ARE YOU PREGNANT? ❑ NO ❑ YES/HOW LONG? _____ NURSING? ❑ YES ❑ NO

- WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.
- OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE DOCTOR. IF ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT.
- I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.
- I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE: _____ DATE: ____/____/____