Dr. Suzanne Kistner-Davis 625 W. McKinley Ave. Decatur, IL 62526

Registration and History

1. Patient Information

Date: _____
Patient Name: (Last, First, Middle Initial)
_____
Address:
_____
_____
_____
Email:_____
Gender: M F
Date of Birth: _____Age:_____
SSN ____-___-____
Married Widowed Single
Separated Divorced Minor
Spouse's Name _____
Number of Children: _____
Patient Employer/School
_____
Occupation: _____
Employer/School Address
_____
_____
Who referred you here?
_____

2. Account Information

Who is responsible for this account?
_____
Relationship to Patient:
_____
Assignment and Release:
I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance company(ies))
_____ and assign directly to Dr. Suzanne Kistner-Davis 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.
Signature: _____

Print:_____

Date_____

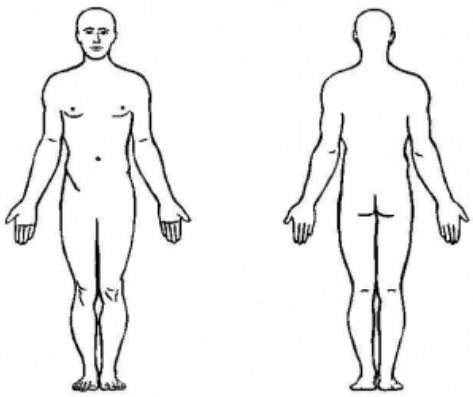
Relationship to Patient _____

3. Phone Numbers

Cell Phone: (____)_____-_____ Home Phone: (____)_____-_____
Work Phone: (____)_____-_____ Best time and place to reach you: _____
IN CASE OF EMERGENCY CONTACT:
Name: _____ Relationship: _____
Home Phone: (____)_____-_____ Work Phone: (____)_____-_____ Cell Phone: (____)_____-_____

4. Patient Condition

Reason for visit: _____
When did symptoms start? _____
Is this condition getting progressively worse? Y N U
Mark an X on the body where you hurt
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe) _____
Type of pain (circle all that apply): Sharp dull throbbing numb aching
Shooting burning tingling cramps stiff swelling other
How often do you have this pain? _____
Is it constant, or does it come and go? _____
Does it interfere with (circle all that apply): work, sleep, daily routine, recreation?
Activities or movements that are painful to perform (circle all that apply):
Sitting standing walking bending lying down



What treatment have you already received for your condition? (Circle all that apply)
Medications Surgery Physical Therapy Chiropractic Services None Other_____
Name(s) 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, Bone Scan _____

Circle Y for yes and N for no to indicate if you have had any of the following:

AIDS/HIV	Y	N	Goiter	Y	N	Multiple Sclerosis	Y	N
Alcoholism	Y	N	Gout	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Heart Disease	Y	N	Pacemaker	Y	N
Appendicitis	Y	N	Heart Surgery	Y	N	Parkinson's Disease	Y	N
Arthritis	Y	N	Hepatitis	Y	N	Pinched Nerve	Y	N
Asthma	Y	N	Hernia	Y	N	Pneumonia	Y	N
Bleeding			Herniated Disk	Y	N	Polio	Y	N
Disorders	Y	N	High Blood			Prostate Problem	Y	N
Bronchitis	Y	N	Pressure	Y	N	Artificial Limb(s)	Y	N
Cancer	Y	N	High			Psychiatric Care	Y	N
Cataracts	Y	N	Cholesterol	Y	N	Rheumatoid Arthritis	Y	N
Drug Abuse	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Emphysema	Y	N	Low Back Pain	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	Migraines	Y	N	Ulcers/Colitis	Y	N
Glaucoma	Y	N	Headaches	Y	N	Venereal Disease	Y	N
Artificial Valve	Y	N	Neck Pain	Y	N	Chemotherapy/		
Difficulty			Sinus Pain	Y	N	Radiation	Y	N
Breathing	Y	N	Other: _____					

Exercise (circle)

None
Moderate
Daily
Heavy

Work Activity (circle)

Sitting
Standing
Light Labor
Heavy Labor

Injuries/Surgeries you've had and dates they occurred

Falls_____
Head injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

Habits (circle where applicable)

Smoking — If you're a smoker, how many years have you smoked? _____
Year you quit smoking _____
Packs/Day_____
Alcohol — Drinks/Week_____
Coffee/Caffeine — Cups/Day_____
High Stress Level — Reason for stress: _____

Allergies

_____
_____
_____
_____
_____
_____

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6. FAMILY HISTORY	Diseases in family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brother(s)		
Sister(s)		
Grandmother(s)		
Grandfather(s)		

7. MEDICATIONS, VITAMINS, HERBS, SUPPLEMENTS	REASON FOR TAKING

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- 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 business manager. 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 legal fees, collection agency fees (up to 50% of your bill), and any other 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 and staff 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 to the information I have provided.

Signature: _____ Date: _____