GREENWOOD
HEALTH CENTER

450 South State Road 135, Suite B
Greenwood, IN 46142
(317) 889-8998

PATIENT REGISTRATION

Patient's Name:_____ D.O.B._____/_____/_____
LAST FIRST MIDDLE INITIAL

Address:_____
CITY STATE ZIP

PLACE AN X NEXT TO YOUR PREFERRED COMMUNICATION METHOD:

Cell: ( ) _____ Home: ( ) _____ Work: ( ) _____

Do we have permission to leave a message on your voicemail? Y / N

Do we have permission to leave a message with the person answering? Y / N

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Living together _____

Occupation:_____ Employer_____

Email_____@_____

Next of Kin or Emergency Contact:_____ Telephone: _____

Relationship:_____

Are your symptoms due to an auto accident or injury at work ? No Yes

**If yes, please notify Front Desk Assistant right now.*

INSURANCE INFORMATION

Primary Insurance:_____ Telephone:_____

Policy/ID #: _____ Group #:_____

Name of Insured:_____Relationship_____Insured D.O.B. ____/____/_____

Insured Address:_____

Secondary Insurance:_____ Telephone:_____

Policy/ID #: _____ Group #:_____

Name of Insured:_____Relationship_____Insured D.O.B. ____/____/_____

Insured Address:_____

(please note we need a copy of all insurance cards and your drivers license in order to file your claims)

LIABILITY

I know and agree that Greenwood Health Center is not responsible for loss or damage to personal valuables.

NOTICE OF PRIVACY

I acknowledge receipt of the Notice of Privacy Practices. Signed:_____

INSURANCE AND PERSONAL RESPONSIBILITY

I understand that health and accident insurance policies are an arrangement between my insurance carrier and myself. I also understand that Greenwood Health Center will prepare and submit any claims and requested reports as a courtesy to me. However, I clearly understand that I am ultimately responsible for all services charged to me and that I am directly responsible for payment. I am aware that payments for self-pay/co-pays are due at the time services are rendered. I may also be responsible for any balances/co-insurance due after insurance payment is made.

Patient's Signature_____Date ____/____/_____

*Guardian's Signature if patient is a minor*_____ *Date*____/____/_____

GREENWOOD HEALTH CENTER

Today's Date_____

Name _____ D.O.B._____/_____/_____

CURRENT SYMPTOMS

Please list your chief complaints:

1._____ 2. _____ 3. _____

Date symptoms began:_____/_____/_____

Are these symptoms: Improving Getting worse About the same Come & Go

On the Diagram below, please indicate where you are experiencing pain or other symptoms, right now.

A = ACHE B = BURNING N = NUMBNESS

P = PINS & NEEDLES S = STABBING O = OTHER

1 – What is your pain RIGHT NOW?

No Pain Worst Pain

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain Worst Pain

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

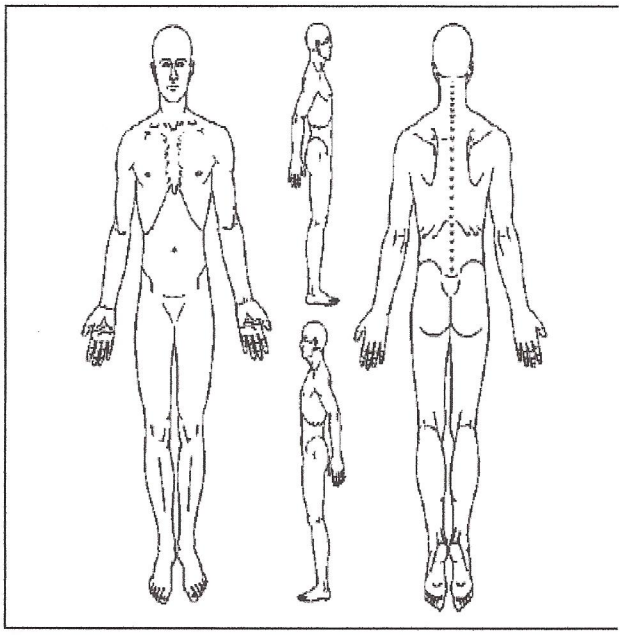
No Pain Worst Pain

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain Worst Pain

0 1 2 3 4 5 6 7 8 9 10



Other Comments: _____

FEMALE X-RAY QUESTIONNAIRE

"In signing this form, I state to the best of my knowledge that I am NOT pregnant and this clinic has my permission to X-ray me for diagnostic interpretation."

Signed:_____ Date:_____/_____/_____

CONSENT TO TREATMENT

By signing this agreement, I consent to have the providers of Greenwood Health Center provide treatment and care, which may include physical medicine, therapy modalities, exams and diagnostic tests/x-rays as deemed medically necessary in my case.

Signed:_____

TREATMENT OF MINORS (leave blank if not applicable)

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Signed:_____ Relationship to minor:_____

Greenwood Health Center, PC – 450 S. State Road 135, Ste. B Greenwood, IN 46142
Tel: (317) 889-8998 Fax: (317) 889-9127

GREENWOOD HEALTH CENTER

450 South State Road 135, Suite B
Greenwood, IN 46142
(317) 889-8998

PATIENT HISTORY

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	☐ MALE ☐ FEMALE	AGE	HEIGHT	WEIGHT

PATIENT MEDICAL HISTORY

Accidents/Falls	☐ Yes	☐ No	Currently Pregnant	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Alcohol consumption?	☐ Yes	☐ No	CVA / Stroke	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
How much? _____			Depression	☐ Yes	☐ No	Latex sensitive	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Dialysis	☐ Yes	☐ No	Neurological	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Bladder disorder	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No	Fainting spells	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Bowel disorder	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Smoking	☐ Yes	☐ No
Broken bones	☐ Yes	☐ No	Had a cold recently	☐ Yes	☐ No	How much? _____		
Bronchitis	☐ Yes	☐ No	Hearing problems	☐ Yes	☐ No	Stomach disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis (B or C)	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	HIV / AIDS exposure	☐ Yes	☐ No	Tremors / Parkinson's	☐ Yes	☐ No

Please list all current medications and vitamins dosages:_____

_____

_____

Please list any medications that you have a history or allergic reaction to: (list what your reaction was):

_____

_____

Please list all previous surgeries:

_____

_____

CARDIOVASCULAR HISTORY

Do you have high blood pressure?	☐ Yes	☐ No	Do you have any heart disease?	☐ Yes	☐ No
Do you have palpitations?	☐ Yes	☐ No	Do you suffer from irregular heartbeats?	☐ Yes	☐ No
Do you have fast heartbeats?	☐ Yes	☐ No	Do you suffer from angina?	☐ Yes	☐ No
Do you have a heart murmur?	☐ Yes	☐ No	Do you have a cardiac pacemaker?	☐ Yes	☐ No
Do you suffer from chest pain?	☐ Yes	☐ No	Have you ever had a stroke?	☐ Yes	☐ No
Have you ever had a heart attack?	☐ Yes	☐ No			

FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased)

			What family member?		
Cancer	☐ Yes	☐ No	Relation:_____	☐ Living	☐ Deceased
Heart disease	☐ Yes	☐ No	Relation:_____	☐ Living	☐ Deceased
High blood pressure	☐ Yes	☐ No	Relation:_____	☐ Living	☐ Deceased
Diabetes	☐ Yes	☐ No	Relation:_____	☐ Living	☐ Deceased
Depression / Mental disorders	☐ Yes	☐ No	Relation:_____	☐ Living	☐ Deceased

Other_____

Other_____

Other_____

Patient Signature	Date

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call Greenwood Health Center to inquire about your personal health information or billing information. Please take a few moments to complete this form.

Such personal involved in your care may include spouses, children, blood relative, roommates, boyfriends or girlfriends, domestic partners, neighbors or colleagues.

I authorize Greenwood Health Center to disclose my health information that is directly related to my current treatment at Greenwood Health Center to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name	Relationship

I do not wish to have my health information disclosed to these individuals involved in my care.

Name	Relationship

Signed: _____

I certify that all the information provided herein is true and correct.

Signed: _____ Witnessed: _____

Print Name: _____ Print Name: _____

Date: _____/_____/_____