WELCOME

Liringis Chiropractic

ACCIDENT & INJURY CENTER

Winston-Salem (336) 768-1004 • Fax (336) 659-1373
3570 Vest Mill Road,#B • Winston-Salem, NC 27103

NEW PATIENT REGISTRATION

Steve Liringis, DC
John Robinson, DC

1 ABOUT YOU

Today's Date: _________ / _________ / _________

Patient Name: ____
LAST FIRST MI

❑ Male ❑ Female

Birthdate: _________ / _________ / _________ Age: ________ SS#: ______________________

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: ______________________ Cell Phone #: ______________________

Work Phone #: ______________________ Ext: ______________________

E-mail Address: ____

Employer: ______________________ How long? ______________________

Employer's Address: ____

____
CITY STATE ZIP

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Are you a full time student? ❑ Yes ❑ No

Do you reside with a relative? ❑ Yes ❑ No

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ___________________

2 IN EVENT OF EMERGENCY

Whom should we contact? ____

Relationship: ____

Home Phone #: ______________________ Cell Phone #: ______________________

Work Phone #: ______________________ Ext: ______________________

Who is your medical doctor? ____

Medical doctor's phone #: ____

Staff Initials: ___________________

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3 HEALTH HISTORY

1. **Do you have or have you had any of the following diseases, medical conditions or procedures?**

❏ Yes Tuberculosis
❏ Yes Kidney Disease
❏ Yes Sciatica
❏ Yes Colon Disease
❏ Yes Paralysis
❏ Yes Anemia
❏ Yes Lung Disease
❏ Yes Stomach/Ulcer
❏ Yes Hi/Low Blood Pressure
❏ Yes Stroke
❏ Yes Seizures

❏ Yes Thyroid Disease
❏ Yes Gout
❏ Yes Heart Disease/Heart Attack
❏ Yes Heart Murmur
❏ Yes Congenital Heart Defect
❏ Yes Heart Surgery/Pacemaker
❏ Yes Transfusion
❏ Yes Cancer
❏ Yes Chemotherapy
❏ Yes Arthritis
❏ Yes Drug Dependence

❏ Yes Diabetes
❏ Yes Hepatitis
❏ Yes Pollo/MS
❏ Yes Bleeding
❏ Yes Ulcers/Colitis
❏ Yes Asthma
❏ Yes AIDS
❏ Yes HIV
❏ Yes ARC
❏ Yes Shingles
❏ Yes Psychiatric Problems

❏ Yes Fainting/Seizures/Epilepsy
❏ Yes Venereal Disease
❏ Yes Rheumatic Fever
❏ Yes Sinus Problems
❏ Yes Frequent Neck Pain
❏ Yes Lower Back Problems
❏ Yes Hepatitis
❏ Yes Glaucoma
❏ Yes Artificial Bone/Joint/Implants

2. Please list any surgeries with dates and/or other serious medical condition(s) not listed above:
____

3. List any past serious accidents with dates: ____
4. Please list anything that you may be allergic to: ____
5. List any family Health History: ____
6. Do you take supplements or vitamins? ❏ Yes ❏ No Do you exercise? ❏ Yes ❏ No ________ hours per week
7. Do you smoke? ❏ Yes ❏ No How much? ______________________ How long? ______________________
8. For women: Are you taking birth control? ❏ Yes ❏ No Are you nursing? ❏ Yes ❏ No
9. **Are you pregnant? ❏ Yes ❏ No If so, how many weeks?** ____

▲ 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.

▲ HIPAA Compliance - Our office is required by law to maintian the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health insurance. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

▲ I authorize the staff to perform any necessary medical services needed during diagnosis and treatment.

▲ 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.

Patient Signature: ____ Date: ______________
Witness: ____ Date: ______________
Staff Initials: ____

Doctor's Initials: ___________________
Staff Initials: ___________________