

Dr. Pamela J. Owens, DC, PC
6934 Beach Dr. SW, Ste 2
Ocean Isle Beach, NC 28469
910-575-2225

Acct. #: _____ Date: _____

Name (Mr., Ms., Mrs.): _____

Home address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

SS#: _____ email: _____

Age: _____ Date of Birth: ____________ Married: _____ Single: _____ other: _____

Occupation: _____ Employer: _____

Office address, City, St: _____ Ph: _____

Spouse's Name: _____ SS#: _____

Spouse's Employer: _____ Spouse's Date of Birth: ____________

Previous Chiropractic Care: yes ___ no ___ Doctor's Name: _____

Insured on policy: _____

Name of Insurance Co: _____

PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARD (S) AND DRIVERS LIC.

Major complaint: _____

Nearest relative/friend who may be called in case of emergency: _____

Relationship: _____ Phone: _____

Who or what source referred you? _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Pamela J. Owens, DC, PC to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, and etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable/ these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature _____ **Date** _____

HISTORY OF CONDITION

In your words, what physical problems are you having today?

1. _____ Height: _____
2. _____ Weight: _____
3. _____ BP: _____

Who is your Primary Care Doctor? _____ Phone: _____

What treatment have you already received for your condition? (Circle all that apply)

Acupuncture Medication Surgery Physical Therapy Chiropractic Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood work _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan _____ Bone Scan _____

Have you **EVER** been diagnosed with any of the following disorders?

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Measles | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio | <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Vascular Disease |

Mark "Yes" or "No" to indicate if you **HAVE OR EVER HAVE HAD** any of the following:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur or congenital heart defect | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement where? | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery or heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Left Arm Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Deliberator, Pacemaker, or Stents | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | Palpations |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Coughing |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal blood pressure high / low | <input type="checkbox"/> | <input type="checkbox"/> | Confusion | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> | Osteopenia/Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung COPD/Disease | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> | Gerd / Reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever | <input type="checkbox"/> | <input type="checkbox"/> | Lupus | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Whooping Cough | <input type="checkbox"/> | <input type="checkbox"/> | Fibermyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss/Gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots | <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Pinched Nerve | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problem | <input type="checkbox"/> | <input type="checkbox"/> | Fractures | <input type="checkbox"/> | <input type="checkbox"/> | Miscarriage |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary/Pain Infection | <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancies |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Infections | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps | <input type="checkbox"/> | <input type="checkbox"/> | Goiter | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

HISTORY OF CONDITION

Are you presently taking medication? Yes No

(If yes, please list and give reason for taking medication. Include vitamins and supplements)

ALLERGIES

Yes No

- Penicillin
- Codeine
- Latex
- Aspirin
- Demerol
- Local anesthetics like Novocain
- Other drugs, medications, or foods (list) _____

HABITS

Smoking- Packs/Day _____ Years _____

Alcohol – Drinks/Week _____

Coffee/Caffeine Drinks-Cups/Day _____

EXERCISE: None Moderate Daily Heavy

WORK ACTIVITY: Sitting Standing Light Labor Heavy Labor

ARE YOU PREGNANT? Yes No Due Date: _____

FAMILY HEALTH HISTORY

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Back Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Mother (Living) (deceased) Age: _____ Ailments: _____

Father (Living) (deceased) Age: _____ Ailments: _____

Brother(s) Age: _____ Ailments: _____

Sister(s) Age: _____ Ailments: _____

Children Age: _____ Ailments: _____

SURGERIES/INJURIES

(Please List Date and Type)
