ADVANCED BACK & NECK PAIN CENTER
PATIENT REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

How did you hear about us: _____

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. Richard McKay & Dr. Travis McKay all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** yes ____ no ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Medications: *(please list all medications and supplements that you currently take)*

Allergies: *(please list all medications that cause allergic reaction)*

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ pulmonary embolism
- ☐ pneumonia
- ☐ tuberculosis
- ☐ respiratory arrest
- ☐ sleep apnea
- ☐ other: _____

Cardiac / Heart and peripheral vascular disease

- ☐ chest pain / angina
- ☐ heart attack, myocardial infarction
- ☐ congestive heart failure
- ☐ other: _____
- ☐ high blood pressure
- ☐ heart murmur, valve disorder
- ☐ mitral valve prolapse
- ☐ bleeding problems
- ☐ irregular heartbeat, arrhythmia
- ☐ peripheral vascular disease
- ☐ deep vein thrombosis

Neurologic Disorders

- ☐ stroke or TIA
- ☐ peripheral neuropathy
- ☐ other: _____
- ☐ parkinson's
- ☐ MS
- ☐ cerebral palsy
- ☐ polio

Bone & Joint Disorders

- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other: _____
- ☐ gout
- ☐ lupus
- ☐ osteomyelitis
- ☐ ankylosing spondylitis

Gastrointestinal Disorders

- ☐ peptic ulcer or stomach ulcer
- ☐ acid reflux, GERD
- ☐ GI bleed
- ☐ other: _____
- ☐ diverticulitis
- ☐ irritable bowel
- ☐ inflammatory bowel disease
- ☐ hepatitis - Type _____
- ☐ liver disease

Genitourinary Disorders

- ☐ urinary tract infection
- ☐ bladder problems
- ☐ kidney problems
- ☐ kidney stones
- ☐ dialysis, kidney failure
- ☐ other: _____

Metabolic & Other Disorders

- ☐ Diabetes x _____ years
- ☐ thyroid problems
- ☐ sickle cell disease
- ☐ high cholesterol or lipids
- ☐ skin disorder _____
- ☐ psoriasis
- ☐ any skin ulcer
- ☐ tooth abscess, gingivitis
- ☐ depression
- ☐ anxiety
- ☐ alcohol or drug dependency
- ☐ other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- ☐ asthma
- ☐ COPD or Emphysema
- ☐ heart attack, myocardial infarction
- ☐ irregular heartbeat, arrhythmia
- ☐ other heart :_____
- ☐ Peripheral neuropathy
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ acid reflux, GERD
- ☐ hepatitis - Type _____
- ☐ liver disease
- ☐ kidney problems
- ☐ diabetes
- ☐ thyroid problems
- ☐ Malignant hyperthermia
- ☐ tuberculosis
- ☐ other lung :_____
- ☐ MS or Parkinson's
- ☐ Lupus
- ☐ Other bone & joint: _____
- ☐ inflammatory bowel disease
- ☐ other GI :_____
- ☐ dialysis, kidney failure
- ☐ psoriasis
- ☐ sickle cell disease
- ☐ sleep apnea
- ☐ congestive heart failure
- ☐ bleeding problems
- ☐ other neuro :_____
- ☐ gout
- ☐ high cholesterol or lipids
- ☐ any skin ulcer

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

_____

_____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- ☐ Medicare
- ☐ Medicaid
- ☐ Blue Cross
- ☐ Blue Shield
- ☐ Major Medical
- ☐ Worker's Compensation
- ☐ Auto Accident
- ☐ Union Plan
- ☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____