PATIENT REGISTRATION FORM PAGE 1

201 Wilshire Blvd. Suite A35,
Santa Monica, CA 90401 ph.: 310-255-0411

Patient Name _____ Birthdate _____ Sex M F
Email Address _____ Social Security # _____/_____/_____
Address _____ City_____
State_____ Zip_____ Mobile Phone# (_____)_____
Occupation _____Employer_____Work Phone (____)_____
Health Plan: _____Subscriber Name_____
Subscriber ID _____ Group #_____
Spouse Name_____ Spouse Employer_____
Primary Care Physician Name _____PCP Phone# (_____)_____

If you were in an Accident: Date of Accident: _____ City &State: _____ Claim #_____
Insurance Company Name: _____ Contact Person _____Contact #_____
Attorney Name: _____ Attorney Phone #: (_____)_____
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:_
❑ Headache ❑ Neck Pain ❑ Mid-back Pain ❑ Low Back Pain ❑ Other _____
Is this? ❑ Work Related ❑ Auto Related ❑ N/A
Date Problem Began: _____ How Problem Began:_____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
0= No Pain 10= Unbearable Pain

In the past week, has your pain interfered with your daily activities (e.g., work, social activities. or household chores?)

0 1 2 3 4 5 6 7 8 9 10
0=No Interference 10=Unable to carry out any

How often are your symptoms present? (Intermittent) ❑ 0 — 25% ❑ 26 — 50% ❑ 51 — 75% ❑ 76 — 100% (Constant)

Is the pain progressively getting worse? Yes No Have you seen any other doctors for this condition? _____
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ❑ No ❑ Yes
Date(s) taken: _____ what areas were taken? _____
PAST HEALTH HISTORY: Please Check and Describe:

Major Surgery/Operations □ Appendectomy □ Back Surgery □ Broken Bones □ Other _____ Major Accidents/Falls_____
MEDICATIONS:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have health insurance coverage with _____and assign directly to Dr. Pamela Ramer, DC, 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 hereby authorize the doctor to release all information necessary to my health or auto insurance, any third party insurance and to my attorney to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In addition, I hereby grant you a voluntary and irrevocable lien against my share of the proceeds of any settlement or award resulting from the disposition of any claim which I may have arising from the captioned accident in which I was involved, and on any amounts available for medical payments under my various insurance coverages, including but not restricted to my automobile insurance and assignment of benefits for all my insurances and the right to cash all insurance checks & accident/claim reimbursement checks made out jointly with me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. , I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, my fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

Patient's Signature _____ Date _____
Consent to Treat a Minor, Guardian or Spouse's Signature Authorizing Care:

Name: _____ Relationship _____Signature _____ Date _____

Ramer Chiropractic
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Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- □ Pneumonia
- □ Rheumatic Fever
- □ Polio
- □ Tuberculosis
- □ Whooping Cough
- □ Anemia
- □ Measles
- □ Mumps
- □ Smallpox
- □ Chicken Pox
- □ Diabetes
- □ Cancer
- □ Heart Disease
- □ Thyroid
- □ Influenza
- □ Pleurisy
- □ Arthritis
- □ Epilepsy
- □ Mental Disorders
- □ Lumbago
- □ Eczema

INTAKE
- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ White Sugar

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE LAST SIX MONTHS:

MUSCLO-SKELETAL CODE
- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Problems
- □ Difficulty Chewing/Clicking Jaw
- □ General Stiffness

NERVOUS SYSTEM CODE
- □ Nervous
- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Confusion/Depression
- □ Fainting
- □ Convulsions
- □ Cold/Tingling Extremities
- □ Stress

GENERAL CODE
- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Fever
- □ Headaches

GASTROINTESTINAL CODE
- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating After Meals
- □ Heartburn
- □ Black/Bloody Stool
- □ Colitis

GENITO-URINARY CODE
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R CODE
- □ Chest Pain
- □ Short Breath
- □ Blood Pressure Programs
- □ Irregular Heartbeat
- □ Heart Programs
- □ Lung Programs/Congestion
- □ Varicose Veins
- □ Ankle Swelling
- □ Stroke

EENT CODE
- □ Vision Programs
- □ Dental Programs
- □ Sore Throat
- □ Earaches
- □ Hearing Difficulty
- □ Stuffed Nose

FEMALES ONLY:

When was your last period?

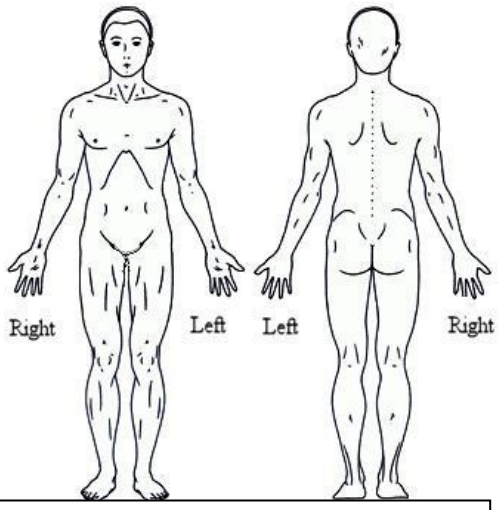
_____

Are you pregnant?

□ Yes □ No

MALE/FEMALE CODE
- □ Menstrual Irregularity
- □ Menstrual Cramps
- □ Vaginal Pain/Infection
- □ Breast Pain/Lumps
- □ Prostate Sexual Dysfunction
- □ Other Problems
- □ _____
- □ _____

Please outline on the diagram the area of your discomfort



A: Achy B: Burning N: Numbness
P: Pins & Needless S: Stabbing O: Other

Family History:

Cancer___ Diabetes___ Blood Pressure__

Heart Problems___ Stroke__

Rheumatoid Arthritis___ Other_____

THANK YOU FOR BECOMING A PART OF THE RAMER CHIROPRACTIC FAMILY