



Maximum Health Clinic, P.C.
Pamela Z. Paetzhold, D.C., N.D., L.Ac.

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West Linn, OR 97068
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PATIENT REGISTRATION

PATIENT INFORMATION

Date: Home Phone #: Cell Phone#:

Patient: Social Security #:
Last Name First Name Initial

Street Address:

City: State: Zip:

Sex: M F Age: Birth Date: Single Married Separated Divorced

Employer:

Address: Occupation: Phone:

Spouse (or responsible party) Name: Birth Date:
Employer Name and Address: Occupation: Phone:

Responsible Party (if a minor): Relationship to Patient:

Emergency Contact: Phone: Relationship to Patient:

Who may we thank for referring you?

INSURANCE INFORMATION

Primary Insurance Information:

Name of Primary Insurer: I.D. #: Group #:
Name of Insured: Phone #:

Secondary Insurance Information:

Name of Secondary Insurer: I.D. #: Group #:
Name of Insured: Phone #:

Accident Insurance Information:

Is this injury accident related? Yes NO If yes: Auto Worker's Comp Other

Name of Accident Insurance Company: Phone #:
Date of Injury: Claim #: Accident Location (city & state):

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with (name of insurance company) and assign directly to Dr. Pamela Paetzhold 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. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services provided to me will be immediately due and payable.

Signature of Insured/Guardian

Date

HEALTH HISTORY

What treatment have you already received for your condition? Chiropractic Naturopathic Acupuncture

Physical Therapy Medications Surgery None Other:

Name & Address of other Doctor (s) who have treated you for your condition (s):

Date of Last: Physical Exam:

Blood Test:

Urine Test:

Spinal Exam:

Spinal X-Ray:

Chest X-Ray:

Dental X-Ray:

MRI, CT Scan, Bone Scan:

Place a mark to indicate if you have had any of the following:

AIDS/HIV Alcoholism Allergy Shots Anemia Anorexia Appendicitis Arthritis

Asthma Auto Immune Bleeding Disorders Breast Lump Bronchitis

Bulimia Cancer Cataracts Chemical Dependency Chicken Pox Diabetes

Emphysema Epilepsy Fractures

Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis

Hernia Herniated Disk High Cholesterol Kidney Disease

Liver Disease Measles Migraines Miscarriage Mononucleosis

Multiple Sclerosis Mumps Osteoporosis Pacemaker Parkinson's Disease

Pinched Nerve Pneumonia Polio Prostate Prosthesis

Psychiatric Care Rheumatoid Arthritis Rheumatic Fever Scarlet Fever Stroke

Suicide Attempt Thyroid Tonsillitis Tuberculosis Tumors, Growths

Typhoid Fever Ulcers Vaginal Infections Venereal Disease Whooping Cough

Other

FAMILY HISTORY-Please indicate if anyone in your family has a history of the following conditions:

Arthritis Asthma Cancer Diabetes Heart Problems

High Blood Pressure Kidney Disease Migraines Stroke Thyroid Disease

Other:

EXERCISE: None Moderate Daily Heavy

WORK ACTIVITY: Sitting Standing Light Labor Heavy Labor

HABITS: Smoking Packs/Day: Alcohol Drinks/Week:

Coffee/Caffeine Drinks Cups/Day: High Stress Level Reason:

Are you pregnant? If yes, Due Date:

INJURIES/SURGERIES: Falls Description: Date:

Head Injuries Description: Date:

Broken Bones Description: Date:

Dislocations Description: Date:

Surgeries Description: Date:

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy:

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