# Welcome!

**Welcome to our office. Please, take your time filling out this paperwork, ask any questions you may have, and do not fill out anything you do not know on this form. Thank you.**

## PATIENT INFORMATION

Date________________________________________
SS#_________________________________________
Patient
Name________________________________________
First Mid. Initial

____________________________________________
Last
Address_____________________________________
City________________________________________
State________________Zip____________________
Sex: ☐ Male ☐ Female Age____________
Birthdate___________________________________
☐ Married ☐ Divorced ☐ Single ☐ Separated
☐ Widowed ☐ Partnered for _________ years
Occupation__________________________________
Employer/School_____________________________

____________________________________________
Whom may we thank for referring you?

____________________________________________
Race:_________________________☐Decline to Disclose
Ethnicity:_____________________☐Decline to Disclose
Preferred Language:____________☐Decline to Disclose
Smoking Status (Circle): Former Smoker/ Smoke sometimes/ Smoke everyday/ Never Smoked ☐Decline

## PHONE NUMBERS

Home Phone__________________________________
Cell Phone__________________________________
Work Phone__________________________________
Best phone to reach you at: ☐H ☐C ☐W
Emergency Contact___________________________
Emergency Contact phone_____________________
Relationship________________________________

## ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Y ☐ N
Date of Accident____________________________
Type of Accident: ☐ Auto ☐ Work ☐ Other

**The Pain Relief Center**
**163 Amherst Street**
**Nashua, NH 03064**
**603-886-4500**
**Nashuachiropractor.com**

## INSURANCE

Subscriber's Name___________________________
Birthdate___________________________________
Relationship to Patient_____________________
Secondary Insurance_________________________

## ASSIGNMENT AND RELEASE

**I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to Dr. Stephen Dohoney 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 authorize the use of my signature on all insurance submissions.**

**The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

____________________________________________
Signature of Patient, Parent, Guardian

____________________________________________
Printed Name

____________________ ____________________
Date Relationship to Patient

## PATIENT CONDITION

Reason for Visit____________________________
When did your symptoms appear?______________
Pain scale 1-10, with 10 being the worst pain________
Is this condition getting progressively worse? ☐ Y ☐ N
Is this pain constant or does it come and go?

____________________________________________
How often do you have this pain?

____________________________________________

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Turning
☐ Bending ☐ Lying Down ☐ All of the above