Pamela Paetzhold D.C | N.D. | L.Ac | R.Dh
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Phone: 503-557-8444
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1832 Willamette Falls Drive
West Linn, Oregon 97068

Patient Registration

Date: **Primary Phone:** **Email:**

Patient: **Social Security #:**

Last Name **First Name** **M.I.**

Street Address:

City: **State:** **Zip:**

Sex: **M** **F** **Age:** **Date of Birth:**

Preferred Appointment Confirmation Method: **Email** **Text** **Other**

Employer:

Address:

Occupation: **Phone:**

Spouse (or responsible party)Name: **Date Of Birth:**

Employer Name & Address:

Occupation: **Phone:**

Consent for Minor Care: **Relationship to Patient:**

Last Name **First Name**

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**

Date of Injury: **Claim #:** **Accident Location (City & State):**

Assignment and Release

I , THE UNDERSIGNED, HAVE GIVEN DR. PAETZHOLD PERMISSION TO TREAT ME.

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**

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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 your for 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 any of the following:

AIDS/HIV		Alcoholism		Allergy Shots		Anemia		Anorexia	
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:

Arthritis		Asthma		Cancer		Diabetes		Heart Problems	
High Blood Pressure		Kidney Disease		Migraines		Stroke		Thyroid Disease	

Mark your level of Exercise:

None		Mild		Moderate		Daily		Heavy	

Level of Work Activity: (Check all that apply)

Sitting		Standing		Mild Labor		Moderate Labor		Heavy Labor	

Habits:

Smoking		Packs/Day		Alcohol		Drinks/Day		Caffeine Drinks		Cups/Day	

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: _____