Patient Registration

Carolyn Gochee, D.C.
595 Russell St. * Craig, CO 81625
(970) 824-3070

Date: _____

Patient Information:

Name: Last: _____ First: _____ MI: _____

Preferred Name: _____ E-mail: _____

Address: Number & Street: _____ Apt./Condo/ Space No:_____

City: _____State: _____ Zip Code: _____

Phone (please include area code): Home: _____Work: _____

Cell: _____

Birth date:_____ Age:_____ Gender:__Male:__Female SSN:_____

Reason for your visit:_____

Feeling well, would like a checkup: ____

Referred by: _____

Place of employment: _____

Address: _____

Primary Medical Doctor: _____

Marital Status: S M D W Spouse's Name:_____Birth date: _____

Please give your insurance card(s) and driver's license to the front desk for a copy to be included with your file.

- I consent to treatment necessary for the care of the above named patient.
- I acknowledge full financial responsibility for services rendered to the above named patient
- I understand payment of charges incurred is due at the time of service unless other arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.
- I further authorize and request all insurance payments be made directly to the treating doctor.
- **I have read and fully understand the above consent for treatment, financial responsibility, and insurance authorization**
- **I herby acknowledge I have received Dr. Gochee's Notice of Privacy Practices (HIPAA).**

Signature:_____Date:_____

Parent or Guardian Signature: _____

(Over)

Name_____ **Date:**_____

Please list in order of importance the areas that you would like help with:

_____

_____

_____

_____

_____

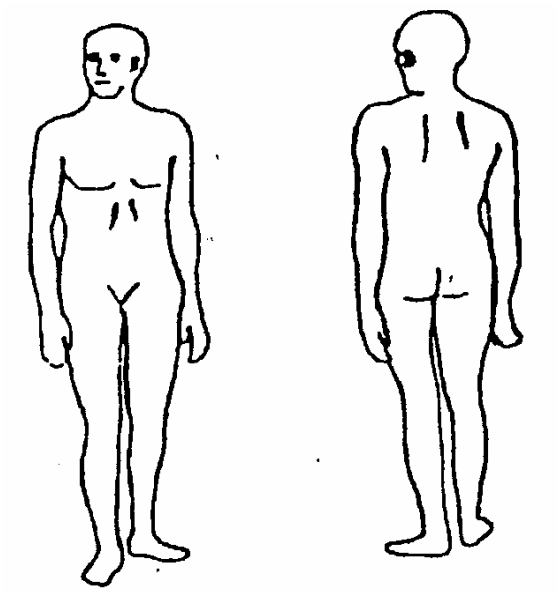
_____

_____

What area of your body would you like to address today?

_____

Please shade in the area of the body that is affected.



When did this begin?

_____

What was the initial cause?

_____

How did it come on? Gradually or Suddenly

Severity of pain: (Scale of 0-10)
0= nonexistent 10= most sever pain

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Any life style changes since this problem came on (Please Describe)

_____

_____

What have you done to care for the problem? (i.e. MD, OTC, ice, heat, massage)

_____

_____

_____

What are your goals for treatment?

_____

_____