# ENTRANCE APPLICATION

*WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.*
*SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?*
*IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!*

First Name _____ Middle _____ Last _____

Gender ❑ Male ❑ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number ___ - ___ - ___ E-mail Address _____

Birthdate _____ Age _____ **Marital Status** S M W D

**Job Title** _____ Work Phone _____

**Spouse's Name** _____ Spouse's Birthdate _____

Social Security Number ___ - ___ - ___

**Person responsible for this account** _____

Name of person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children–Names & Ages _____

_____

**In case of emergency, whom should we contact?** _____

**Phone** _____

**FAMILY PHYSICIAN:** _____

**What is your primary complaint?** _____

_____

**IS THIS WORKMAN'S COMPENSATION?** _____ **IS THIS PERSONAL INJURY?** _____

I give permission to communicate with me (including pre-recorded telephone calls). I understand that I am not required to sign this agreement to receive treatment. I can choose to opt-out of this agreement at any time.

**Patient Signature** _____

**Patient Informed Consent**

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

**Patient Signature** _____

| **(Office use only)** | **Account Number** | **Date** |
|---|---|---|

Dennis Tillotson DC

Patient: _____

## Chief Complaint Form

### Chief Complaint

Case Title: _____

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (select one or more)

| | | | |
|---|---|---|---|
| ☐ Bending | ☐ Bowel Movements | ☐ Coughing | ☐ Daily Routine |
| ☐ Driving | ☐ Getting Up | ☐ Lifting | ☐ Lying Down |
| ☐ Pulling | ☐ Pushing | ☐ Reading | ☐ Sitting |
| ☐ Sleeping | ☐ Sneezing | ☐ Standing | ☐ Turning my head |
| ☐ Urination | ☐ Walking | ☐ Working | ☐ Other (please describe) _____ |

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____

Spinal X-ray: ____/____ CT Scan: ____/____

MRI: ____/____ Other Scans or X-rays: ____/____