ELLEN POTTHOFF, D.C.
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NEW PATIENT REGISTRATION FORM *(Please Print)*

Name:_____ **Gender** ____ **Date of Birth:**_____

Street Address_____ **Phone (Cell/Landline):** _____

City_____ **State** ____ **Zip**_____ **Email:**_____

If patient is a minor, Name of Parent(s)_____

Marital Status_____ **Name of Spouse/Partner:**_____

Occupation:_____ **Work Phone:**_____

Employer: _____

Employer Address (C/S/Z) _____

Insurance Co _____ **Policy No.** _____

Name of Insured: _____ **Social Security No.** _____

Emergency Contact: _____ **Ph. #**_____ **Relationship** _____

Who referred you and/or how did you find me? (ie., website, newsletter, etc.) _____

PAYMENT TERMS:

Payment in full is expected at time of service. *Reduced billing charges help us keep your costs down*. ***If an extended payment is necessary, please notify the office IN ADVANCE to work out a payment plan with us***. Our past-due accounts are periodically turned over to a collection agency. If your account is assigned, you agree to pay for all costs necessary to collect the amount due Ellen Potthoff, D.C., N.D. Thank you.

I have read the above payment policy and agree to abide by it for all services received through Ellen Potthoff, D.C.

_____ Date: _____
Signature (parent, if patient is a minor)

Please list the #1 reason why you came in today: _____

_____

Do you have other health concerns? _____

HEALTH HABITS:

Hobbies: _____

Exercise/Physical Activity: _____ How often?_____

Sleep: (How many hours/day) _____ (Light/Heavy/Insomniac)

Stress Level: High/Average/Low Occurrence of Major Stressful Event: _____

Alcohol Use: Yes/No If yes, how much, how often?_____

Tobacco Use: Yes/No If yes, how much, how often? _____

Caffeine Use: Yes/No If yes, how much, how often? _____

Diet: Do you eat (please circle): Junk Food / Standard American / Wholesome / Vegetarian / Vegan / Macrobiotic / Raw Foods / Other: _____

Briefly describe your diet: _____
Please list all vitamins, minerals and other supplements you take: _____

_____

Please list all medications that you take (both prescription and over-the-counter): _____

_____

PAST MEDICAL HISTORY (please include dates)

Major illnesses: _____

Past Surgeries _____

Please mark "N" for any problems that you have NOW, and "P" for any PAST problems.

	Allergies		Eczema		Stroke
	Arthritis		Headaches (frequent)		Thyroid problems
	Asthma		Heart problems		Trauma (major)
	Blood Disease		Herpes		Tuberculosis
	Cancer		Hypertension		Urinary infection
	Colds (frequent)		Hypoglycemia		Venereal disease
	Diabetes		Nervous breakdown		Other:
	Digestive problems		Neurosis/Psychosis		
	Ear infections		Pneumonia		

PAST MEDICAL CARE

Where did you last receive medical care?_____

For what reason?_____ Date of last physical exam?_____