Kolossal Healthcare Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**WORK PHONE**
PATIENT BIRTH DATE	**PATIENT SSN**	**SEX** ❑ Male ❑ Female	**MARITAL STATUS** ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**		**EMPLOYER PHONE**

INSURED/RESPONSIBLE PARTY INFORMATION		**RELATION TO PATIENT:** ❑spouse ❑parent ❑guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)	**ADDRESS (if different from patient)**			
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**
SECONDARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**

PRIMARY DOCTOR/FAMILY DOCTOR	**REFFERING DOCTOR**	
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

Authorization to release health information to:			
Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**

Kolossal Healthcare Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	AGE	WEIGHT lbs.	HEIGHT Feet Inches

Who is your primary/family doctor?	If you were referred to this clinic by another doctor please list the doctor's name here.

Allergies

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Iodine/Shellfish/Contrast Dye
❑ Latex **OTHER:** **OTHER:** **OTHER:** **OTHER:**

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Substance Abuse			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled (reason _____)
☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any surgeries related to your painful condition.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed ❑ CAD coronary artery disease ❑ Drug/alcohol abuse ❑ Migraines/headaches
❑ Allergies ❑ Cancer ❑ Fibromyalgia ❑ Neuropathy
❑ Anemia ❑ Chest pain ❑ Heart disease ❑ Pulmonary embolism/blood clot in legs
❑ Arthritis conditions ❑ CHF congestive heart failure ❑ Hypertension ❑ Seizure disorders
❑ Asthma ❑ Depression ❑ Infection problems ❑ Shortness of breath
❑ Bleeding problems ❑ Diabetes ❑ Kidney problems

Other:

PAIN Medications: List any PAIN medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Other Medications: List any medications you are currently taking (name ONLY no dosage or prescribing doctor):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	MEDICATION	MEDICATION