ELLEN POTTHOFF, D.C., N.D.
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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., N.D.

_____ 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 place CHECKMARK (✓) in "**C**" for Current problems, "**P**" for PAST condition, "**S**" for SELF, and "**F**" for FAMILY.

C	P	S	F		C	P	S	F		C	P	S	F	
				Allergies					Ear Infections					Neurosis/Psychosis
				Arthritis					Eczema					Stroke
				Asthma					Headaches (frequent)					Thyroid problems
				Blood Disease					Heart problems					Trauma (major)
				Cancer					Herpes					Tuberculosis
				Colds (frequent)					Hypertension					Urinary infection
				Diabetes					Hypoglycemia					Venereal Disease
				Digestive Issues					Nervous breakdown					Other

PAST MEDICAL CARE

Where did you last receive medical care?_____

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