Dr. Pamela J. Owens, DC, PC
6934 Beach Dr. SW, Ste 2
Ocean Isle Beach, NC 28469
910-575-2225

Acct. #: _____ Date: _____

Name (Mr., Ms., Mrs.): _____
Home address: _____ Phone: _____
City: _____ State: _____Zip: _____Cell: _____
SS#: _____ email: _____
Age: _____ Date of Birth: ______________ Married: _____ Single: _____ other: ____
Occupation: _____Employer: _____
Office address, City, St: _____Ph: _____

Spouse's Name:_____SS#:_____
Spouse's Employer:_____Spouse's Date of Birth:___________

Previous Chiropractic Care: yes___no____Doctor's Name:_____

Insured on policy:_____
Name of Insurance Co:_____

PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARD (S) AND DRIVERS LIC.

Major complaint:_____
Nearest relative\friend who may be called in case of emergency:_____
Relationship:_____Phone:_____
Who or what source referred you? _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Pamela J. Owens, DC, PC to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, and etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable/ these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature _____ Date _____

At The Beach Chiropractic Health Center
Dr. Pamela J. Owens
6934 Beach Drive, SW Suite 2
Ocean Isle Beach, NC 28469
Phone: 910-575-2225 Fax 910-575-2275 www.drpamelaowens.com

Comprehensive Health History

PLEASE USE BLUE OR BLACK INK ONLY

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Primary Doctor Name and Address

Preferred Pharmacy (Address / Phone):

PAST MEDICAL HISTORY: *Check all that apply* ☐ *None Apply*

- ☐ Heart Attack
- ☐ Heart failure
- ☐ Abnormal heartbeat
- ☐ High blood pressure
- ☐ Stroke
- ☐ Blood clots in leg
- ☐ Blood clots in lung
- ☐ Poor circulation
- ☐ High Cholestrol
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Thyroid
- ☐ Stomach ulcers
- ☐ Gastric reflux
- ☐ Hiatal hernia
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Cirrhosis
- ☐ Hepatitis (A, B or C)
- ☐ HIV / AIDS
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Depression
- ☐ ADHD
- ☐ Seizures
- ☐ Migraine
- ☐ Cerebral palsy
- ☐ Downs syndrome
- ☐ Spina Bifida
- ☐ Neurofibromatosis
- ☐ MRSA
- ☐ Neuropathy: ☐ Hands or ☐ Feet
- ☐ Cancer: _____ (Type / treatment)
- ☐ Diabetes: year diagnosed _____

Currently controlled with: ☐ Insulin ☐ oral medications ☐ diet

☐ Other: _____

PAST SURGICAL HISTORY: ☐ ***No Prior Surgery***

Operation	Date	Surgeon / Hospital

Have you ever had general anesthesia? ☐ No ☐ Yes
If YES, have you had any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia:

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Name: _____ Date of Birth: _____

MEDICATIONS (prescribed and over the counter): ☐ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES TO MEDICATIONS: ☐ ***No Allergies***

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: ☐ ***No Allergies*** ☐ **Yes** _____ (List Metals)

SOCIAL hISTORY:

Work Status:

☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children ☐ No ☐ Yes How Many? _____

Do you live alone? _____ If no, who lives with you? _____

Are you currently smoking: _____ If yes, yow many packs a day? _____ For how may years? _____

Have you quit somking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco? _____

Alcohol Use: ☐ Never ☐ Rare ☐ Social ☐ Frequently (more than twice a week)
☐ Alcoholic ☐ Recovering Alcoholic

Illegal Drug Use: ☐ Never ☐ In the past ☐ Currently Types of Drugs: _____

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FAMILY HISTORY: Check all that apply ☐ ***None Apply***

	Father	Mother	Brother	Sister	Son	Daughter	Other (Grandparents, etc) (Specify)
Heart Disease							
Arthritis							
Seizure							
Bleeding Problems							
High Blood Pressure							
Stroke							
Gout							
Alcoholism							
Cancer							
Blood Clots							
Kidney Problems							
Diabetes							
Lung Problems							
Mental Illness							
Other							

Other Family History: _____

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REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?

☐ Fever	☐ Sleep apnea (snoring)	☐ Nausea
☐ Chills	☐ Hoarseness	☐ Vomiting
☐ Weight loss	☐ Cough	☐ Diarrhea
☐ Weight gain	☐ Trouble swallowing	☐ Constipation
☐ Vision changes	☐ ***Chest pain***	☐ Hemorrhoids
☐ Glasses / Contacts	☐ ***Palpitations***	☐ Stomach pain
☐ Hearing loss	☐ Swollen ankles	☐ Urinary difficulty
☐ Dizziness	☐ ***Shortness of breath***	☐ Anxiety
☐ Ear pain	☐ Seasonal allergies	☐ Hyperactivity
☐ Nosebleeds	☐ Skin rashes	☐ Memory loss
☐ Toothache	☐ Swollen glands	☐ Blackouts
☐ Gum problems	☐ Poor appetite	☐ Headache

☐ ***I have not experienced any of the above symptoms in the last 30 days.***

☐ Other:

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient / family:

Physician Signature: Date: