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

ORTHOPEDIC 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):

____
____
____

If not referred, how did you choose this office? ______________________

Why are you seeing the doctor today? ______________________

How long has the pain / problem been present? ______________________

Has the pain / problem worsened recently? ☐ No ☐ Yes How recently? ______________

What started the pain / problem? ______________________

Quality of the pain. ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain / problem better? ______________________

What makes the pain / problem worse? ______________________

Is the pain *(check all that apply)*: ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

Did this problem start at work? ______________________

Have you already filed or will you file a workers' Compensation claim? ______________

Have you missed work because of this problem? ______________________

What other treatments have you tried?

☐ Physical Therapy/Ecercise ☐ TENS unit ☐ Narcotic medications ☐ Cast/boot
☐ Massage/Ultrasound ☐ Traction ☐ Anti-Inflammatories ☐ Orthotics
☐ Manipulation ☐ Surgery ☐ Steroid injections ☐ Braces

Previous physicians seen for this problem

Physician	Specialty	City	Treatment

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ORTHOPEDIC HISTORY

Name: ______________________ Date of Birth: ______________

Medications taken for this problem

Name of Medication	Dose	Reason

X-Rays and Tests for this problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Other			

Because of this problem, have you filed or do you plan to file a lawsuit? ☐ Yes ☐ No

If you have previously completed ***a Comprehensive Health History*** during a visit to our practice, have there been any changes to your medical history, surgical history or medications since that time?

Please describe any changes below:

FOR OFFICE USE ONLY

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

Physician Signature: Date: