

Denver Biofeedback Clinic, Inc.

Patient Registration

Name: _____

Street Address: _____ Apt #: _____ City: _____

State: _____ Zip code: _____ Social Security #: _____

Home phone #: (_____) - _____ Work phone #: (_____) - _____

Cell phone #: (_____) - _____ Pager #: (_____) - _____

Date of Birth: _____ Gender: Male _____ Female _____ Dominant Hand: R _____ L _____

Marital Status: Married _____ Single _____ Divorced _____ # of Children: _____ Ages: _____

Employment status: Full time _____ Full time with restrictions _____ Part time _____ Student _____ Not working _____

In case of emergency please notify: _____

Address: _____ Phone: _____

Work injury: _____ Automobile accident: _____ Major Medical: _____

Are you the insured?: _____ If no: Name of insured: _____ SS # of insured: _____

If Major Medical: Group #: _____ ID#: _____

Date of injury: _____ Insurance Claim #: _____

Insurance company covering this claim: _____

Insurance adjuster: _____ Phone #: (_____) - _____

Insurance address: _____

Employer's name: _____ Phone: (_____) - _____ Fax: (_____) - _____

Employer contact/supervisor: _____ Have you changed employers since your injury?: _____

Name of referring physician: _____ Phone: (_____) - _____ Fax: (_____) - _____

Physician address: _____

Diagnosis: _____

Patient or Guardian signature required:

I authorize Denver Biofeedback Clinic, Inc. to perform evaluation and treatment of myself as needed. I authorize the release of any medical or other information necessary to my physicians and insurance company to process this claim. I furthermore authorize payment of medical benefits to Denver Biofeedback Clinic, Inc. I realize that I am fully responsible for any payments not covered by my insurance except where prohibited by law. "I hereby acknowledge that I have received a copy of the Provider's Notice of Privacy Rights."

Signed: _____ Date: _____

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Describe your work and your title or position: _____

If you have work restrictions, please describe them: _____

Please describe how you were injured: _____

Have you had any surgeries related to this injury?: (date/description): _____

Please date and describe any other major illnesses, accidents or surgeries that you have had: _____

List all medications and dosages that you are currently taking: _____

Do you have a history of Diabetes _____ Seizures _____ Thyroid dysfunction _____

Briefly describe activities that are limited due to your current condition: _____

What are your goals and expectations for biofeedback and this training. _____
