Chiropractic Registration & History

PATIENT INFORMATION

Date _____

Name _____
LAST NAME FIRST NAME INITIAL

SS# _____

Address _____

_____
CITY STATE ZIP

Sex: ❑ M ❑ F Age_____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation _____

Employer _____

Employer Address _____

_____
CITY STATE ZIP

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

ID# _____ GRP# _____

Insurance Phone # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Company _____

ID# _____ GRP# _____

Insurance Phone # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home_____ Work _____ Ext. _____

Cell _____ E-mail Address_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?
❑ Auto Insurance ❑ Employer ❑ Other

Attorney Name (if applicable) _____

Address _____

Phone # _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms begin _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark and X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

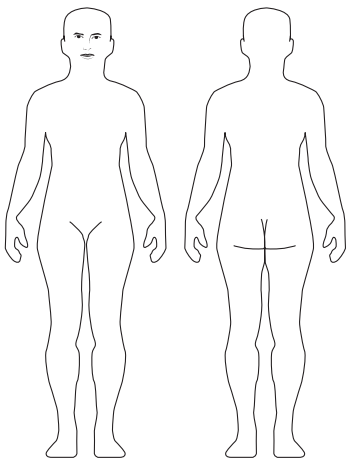
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that re painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down



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PATIENT INFORMATION

Have you ever seen a Chiropractor before? ❑ Yes ❑ No

What treatment have you already received for your condition? ❑ Chiropractic Services ❑ Physical Therapy ❑ Medication ❑ Surgery ❑ None ❑ Other _____

Name of other doctor(s) who have treated you for your condition _____

Date of 1st treatment _____ Number of treatments in the last 12 months _____

Date of last: Spinal Exam _____ Spinal X-Ray _____ Other X-Ray _____ MRI, CT-Scan, Bone Scan _____

PLEASE CHECK ☑ SYMPTOMS YOU CURRENTLY HAVE:

❑ Balance Impairment	❑ Headaches	❑ Loss of Memory	❑ Vertigo
❑ Burning Eyes	❑ Lightheadedness	❑ Nausea	❑ Visual/Sensory Disturbance
❑ Depression	❑ Loss of Concentration	❑ Ringing/Buzzing in Ears	

PLEASE CHECK ☑ CONDITIONS OR SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

❑ Aids/HIV	❑ Cataracts	❑ Herniated Disk	❑ Parkinson's Disease	❑ Tuberculosis
❑ Anemia	❑ Chemical Dependency	❑ Herpes	❑ Pinched Nerve	❑ Tumors, Growths
❑ Anorexia	❑ Diabetes	❑ High Blood Pressure	❑ Pneumonia	❑ Ulcers
❑ Appendicitis	❑ Emphysema	❑ High Cholesterol	❑ Polio	❑ Varicose Veins
❑ Arthritis	❑ Epilepsy	❑ Jaw Pain/TMJ	❑ Prosthesis	❑ Whiplash
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Psychiatric Care	❑ Other _____
❑ Blood Clots	❑ Goiter	❑ Liver Disease	❑ Rheumatoid Arthritis	_____
❑ Breast Lump	❑ Gout	❑ Mononucleosis	❑ Rheumatic Fever	_____
❑ Bronchitis	❑ Heart Disease	❑ Multiple Sclerosis	❑ Scarlet Fever	_____
❑ Bulimia	❑ Hepatitis	❑ Osteoprosis	❑ Stroke	_____
❑ Cancer	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems	_____

EXERCISE
❑ None ❑ Daily ❑ Moderate ❑ Heavy

WORK ACTIVITY
❑ Sitting ❑ Light Labor ❑ Standing ❑ Heavy Labor

LIFESTYLE
❑ Smoking Packs/Day _____ ❑ Coffee/Caffeine Cups/Day _____
❑ Alcohol Drinks/Week _____ ❑ High Stress Level Reason: _____

Are you pregnant? ❑ Yes ❑ No Due Date: _____

Injuries/Surgeries you have had	Description	Date
Accidents/Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any care and treatment, any fees for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my conditions deemed appropriate through the use of Chiropractic Health Care, and I give authority for those procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while I am an active patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for ay medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information

There are several circumstances in which we may have to disclose your health care information. "We may have to disclose your health information to another health care provider or hospital if it's necessary to refer you to them for the diagnosis , assessment or treatment of your condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment or your services. We may need to use your health information within our practice for quality control or operational purposes.

We have a more complete notice that provides of how your health information may be used or disclosed. You have the right to review that notice before you sign the consent form (164.520) We reserve the right change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions, however if we agree with you restrictions, the restriction is binding us.

Your Right to Revoke your Authorization

You may revoke your consent to us at any time, however, your revocation must be on writing. We will not be able to honor your revocation request if we have already released your health information before we received the request to revoke your authorization. If you were required to give your authorization a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

Print Name Authorized Provider Representative

Signature Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks- As with any health care procedure, complications are possible with any chiropractic manuliplation. Complications could include fractures of the bone, muscular strain, ligamentous sprain, dislocations of joints, and injury intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries to the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablets. The risk of cerebrovascular injury or stoke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Other treatment options which could be considered may include the following

Over-the-counter analgesics- The risks of these medications includes irritation to stomach, liver and kidneys; and other side effects in a significant number of cases.

Medical care-typically anti-inflammorty drugs, tranquilizers, and analgesics. Risks of these drugs include multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalizations in conjuctions with medical care add the risks of exposure to virulent communicable disease in a significant number of cases.

Surgery-in conjunction with medical care adds the risks of adverse reactions to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated; Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that the delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above chiropractic treatment. I have read the explanation above the chiropractic treatment. I have had the opportunity to have any questions answered to my satisfactions. I have freely decided to undergo the recommend treatment, and hereby give my full consent to treatment.

Signature/Date Print name