# Patient Registration

Name: _____

Date: _____

## Personal Information

Date of Birth: _____ Age: _____

Address: _____

City/State/Zip Code: _____

Home Phone: (  ) _____ Work Phone: (  ) _____

Cell Phone: (  ) _____ Mobile Carrier: _____

Soc. Sec. #: _____ Sex: M F Marital Status: S M D W

Race (Circle) Asian African American Caucasian Hispanic Other _____

Occupation: _____

Employer's Name: _____

Work Address: _____ City/State/Zip Code: _____

**Emergency Contact (Name, relationship):** _____

**Phone:** _____ **Cell:** _____

Spouse's Name: _____ M F DOB _____

Child's Name: _____ M F DOB _____

Child's Name: _____ M F DOB _____

Child's Name: _____ M F DOB _____

## Insurance Information

Insured's Name _____ Relationship to Patient: _____

Insured's Soc. Sec. # _____ Insured's Date of Birth: _____

Insured's Employer: _____ Phone number: _____

Insurance Carrier _____

*Please make sure we get a copy of your Insurance Card with Photo ID.*

Who may we thank for referring you / which event did you attend? _____

Would you be interested in a welcome packet for our online patient portal? Yes No

Email: _____ May we email appointment reminders? Yes No

Would you be interested in our E-newsletters for updates on events and other information? Yes No

# Informed Consent for Chiropractic Care

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatments or healthcare if he is aware that such care may be contra-indicated. Again it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I also understand that if I am accepted as a patient by a physician at WELLNESSFIRST Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient/Guardian Signature: _____ Date: _____

wellness first
OF SULLIVAN
WELLNESS AWAITS YOU

# Authorization and Release

*Please read and initial each line below*
*and sign at the bottom.*

_____I hereby authorize **WellnessFirst Chiropractic** to release information requested by my insurance carrier and/or Workers' Compensations carrier. Additionally, I authorize **WellnessFirst Chiropractic** to release information to any hospital or physician I may be referred to by this health care provider.

_____I hereby authorize assignment and payment directly to **WellnessFirst Chiropractic** of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges. I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible. I also acknowledge that I am responsible for reasonable interest, collection, fees, attorney fees of the greater of a) forty percent (40%) or b) $300.00 of the outstanding balance and/or court costs incurred in connection with any attempt to collect amounts I may owe.

_____Payment is due at the time services are provided. Every effort is made to bill most insurances. Your Cooperation is essential – please provide correct and current copies of any and all insurance cards. If there has been a change in your insurance, address, telephone number, and/or employment since your last visit, please notify the receptionist prior to being seen by the health care provider. If special arrangements are necessary, please speak with the office manager prior to being seen.

_____We want to thank you for choosing us as your chiropractic provider. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients. Our office does reserve the right to charge a $20 no show fee for a cancellation with less than a 24-hour notice and broken appointments. Thank you for your consideration of our policies.

Patient/Guardian Signature: _____ Date: _____

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purposed of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient my request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

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The following information is whom we may speak to about your health issues and give us permission to leave messages on voicemail or answering machine.

Patient's Name: _____

List Anyone we may speak to: _____

_____

_____

Can we leave a message on voicemail or answering machine? Yes No

Circle the following that we can leave messages about: Referrals Appointments X-Ray Labs Other

By signing below you acknowledge that you have received and reviewed this Consent Form.

Patient Signature: _____ Date: _____

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**Patient Information** **Patient:**_____ **Date:**_____

Name and Phone Number of Medical Doctor:_____

Please list the date of last: Physical Exam_____ Spinal Exam _____

Blood Test _____ _____ Chest X-ray_____ Spinal X-Ray_____

MRI / CT / Bone Scan _____

For Women: Are you Pregnant? Yes No Due Date _____

For Women: Any pregnancy, birthing complications? Please Explain. _____

_____

For Women: What is the date of your last Mammogram? _____

**Family Health History**: List any diagnosed health conditions and untimely deaths. List condition, then relationship to you. Family to Include: Parents, siblings, maternal and paternal grandparents.

_____

_____

_____

Reason for Visit / Primary Complaint: _____

When did this symptom begin? _____

Is this from injury, if yes: _____

What have you tried already? Medicine Surgery Physical Therapy Chiropractic Nothing Other

Secondary Complaint: _____

When did this symptom begin? _____

Is this from injury, if yes: _____

What have you tried already? Medicine Surgery Physical Therapy Chiropractic Nothing Other

Other Complaint: _____

When did this symptom begin? _____

Is this from injury, if yes: _____

What have you tried already? Medicine Surgery Physical Therapy Chiropractic Nothing Other

***Please Read Carefully:*** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Example:

**No Pain** _____ **Worst Pain**

**0 1 (2) 3 4 (5) 6 7 (8) 9 10**

Headache Neck Low Back Pain

**RIGHT NOW?**

No Pain_____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10

**TYPICAL or AVERAGE pain?**

No Pain_____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10

**AT ITS BEST (How close to "0" does your pain get at its best)?**

No Pain_____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10

**What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

No Pain_____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10

## Current Symptoms and Past History Patient:_____Date: _____

**Please check if you have had any of these conditions in the past or are currently dealing with them. If no, leave blank.**

| **Cardiovascular/Heart** | Past | Current | **Neurologic** | Past | Current | **Respiratory** | Past | Current |
|---|---|---|---|---|---|---|---|---|
| High Cholesterol | | | Stroke | | | Asthma | | |
| Poor Circulation | | | Seizures | | | Tuberculosis | | |
| Hypertension | | | Paresthesia/Numbness | | | Bronchitis | | |
| Irregular Heartbeat | | | Dizziness | | | Emphysema | | |
| Heart Disease | | | Memory Loss | | | COPD | | |
| Heart Attack | | | Severe Headaches | | | **Lymphatic** | | |
| Chest Pain/Tightness | | | Weakness | | | Anemia | | |
| Congestive Heart Failure | | | Tremors | | | Hepatitis | | |
| Murmur | | | Carpal Tunnel | | | HIV/AIDS | | |
| Shortness of Breath | | | Vertigo | | | Swelling Lymph Nodes | | |
| Swollen Legs | | | Restless Leg Syndrome | | | Leukemia | | |
| **General** | | | Tingling | | | Lymphatic Malignancy | | |
| Chronic Fatigue | | | Speech Difficulties | | | **Endocrine** | | |
| Heat/Cold Intolerance | | | Migraines | | | GOUT | | |
| Weight Gain | | | **Musculoskeletal** | | | Hyperthyroidism | | |
| Weight Loss | | | Osteoporosis | | | Hypothyroidism | | |
| Sweating | | | Scoliosis | | | Diabetes | | |
| Insomnia | | | Arthritis | | | **Gastrointestinal** | | |
| Developmental Issues | | | Back Pain/Stiffness | | | Gall Bladder | | |
| Cancer | | | Low Back Pain | | | Irritable Bowel | | |
| **Skin** | | | Headache | | | Constipation | | |
| Edema | | | Muscle Ache | | | Diverticulitis | | |
| Rash | | | Neck Pain/Stiffness | | | Acid Reflux/GERD | | |
| Skin Cancer | | | Disc Degeneration | | | Heartburn | | |
| Itching | | | Sciatica | | | Crohn's Disease | | |
| **Genitourinary** | | | Knee Pain | | | Ulcers | | |
| Kidney Disease | | | Hip Pain | | | Hernia | | |
| Kidney Stones | | | Shoulder Pain | | | **Ear, Nose and Throat** | | |
| Burning Urination | | | Arm/ Hand Pain | | | Difficulty Swallowing | | |
| Frequent Urination | | | Leg/Foot Pain | | | Ear Infections | | |
| Urinary Tract Infection | | | Loss of Motion | | | Hearing Loss | | |
| Incontinence | | | Fibromyalgia | | | Ringing in the Ears | | |
| **Psychiatric** | | | **Eyes** | | | Sinus Infections | | |
| Depression | | | Blurred Vision | | | | | |
| Anxiety | | | Cataracts | | | | | |
| ADD/ADHD | | | Glaucoma | | | | | |

**Patient Lifestyle** **Patient:**_____ **Date:** _____

**Injuries, Hospitalizations and Surgeries:** **None**

Severe Falls: Month / Year

_____ _____

Head Injuries: Month / Year

_____ _____

Fractures Month / Year

_____ _____

Hospitalizations Month / Year

_____ _____

_____ _____

Surgeries Month / Year

_____ _____

_____ _____

_____ _____

Have you ever been involved in a motor vehicle accident? If yes, please describe: _____

_____

_____

_____

**Social History:** (Circle all that apply to you)

Caffeine use: None Lightly Moderately Heavily

Drink Alcohol: occasional often never How much? _____

How many glasses of water do you drink a day? _____

| Name of Medication, list or circle: NONE | Dosage | How many do you take a day? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies to Medication: _____

_____

Exercise: none infrequently regular frequent & heavy _____

Cigarettes/Tobacco: current every day former never How many years?: _____

Work Environment: constant sitting constant standing requires lifting stressful

_____

In what position do you sleep? Back Side Stomach