

## 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: \_\_\_\_\_



**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.

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 or 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 History	Living	Deceased	Age	Diseases
Mother				
Father				
Sibling				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

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

**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 0 1 2 3 4 5 6 7 8 9 10 Worst Pain  
 Headache Neck Low Back Pain

**RIGHT NOW?**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**TYPICAL or AVERAGE pain?**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**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.**

<b>Cardiovascular/Heart</b>	Past	Current	<b>Neurologic</b>	Past	Current	<b>Respiratory</b>	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			<b>Lymphatic</b>		
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		
<b>General</b>			Tingling			Lymphatic Malignancy		
Chronic Fatigue			Speech Difficulties			<b>Endocrine</b>		
Heat/Cold Intolerance			Migraines			GOUT		
Weight Gain			<b>Musculoskeletal</b>			Hyperthyroidism		
Weight Loss			Osteoporosis			Hypothyroidism		
Sweating			Scoliosis			Diabetes		
Insomnia			Arthritis			<b>Gastrointestinal</b>		
Developmental Issues			Back Pain/Stiffness			Gall Bladder		
Cancer			Low Back Pain			Irritable Bowel		
<b>Skin</b>			Headache			Constipation		
Edema			Muscle Ache			Diverticulitis		
Rash			Neck Pain/Stiffness			Acid Reflux/GERD		
Skin Cancer			Disc Degeneration			Heartburn		
Itching			Sciatica			Crohn's Disease		
<b>Genitourinary</b>			Knee Pain			Ulcers		
Kidney Disease			Hip Pain			Hernia		
Kidney Stones			Shoulder Pain			<b>Ear, Nose and Throat</b>		
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		
<b>Psychiatric</b>			<b>Eyes</b>			Sinus Infections		
Depression			Blurred Vision					
Anxiety			Cataracts					
ADD/ADHD			Glaucoma					

