

CHIROPRACTIC REGISTRATION AND HISTORY

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PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone (____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

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INSURANCE INFORMATION

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)
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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

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PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone (____) _____ Work Phone (____) _____

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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 Worker Comp. Other
Attorney Name (if applicable) _____

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PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse? Yes No Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 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 are painful to perform Sitting Standing Walking Bending Lying Down



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HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

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

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV Yes No Chicken Pox Yes No Liver Disease Yes No Rheumatoid Arthritis Yes No

Alcoholism Yes No Diabetes Yes No Measles Yes No Rheumatic Fever Yes No

Allergy Shots Yes No Emphysema Yes No Migraine Headaches Yes No Scarlet Fever Yes No

Anemia Yes No Epilepsy Yes No Miscarriage Yes No Stroke Yes No

Anorexia Yes No Fractures Yes No Mononucleosis Yes No Suicide Attempt Yes No

Appendicitis Yes No Glaucoma Yes No Multiple Sclerosis Yes No Thyroid Problems Yes No

Arthritis Yes No Goiter Yes No Mumps Yes No Tonsillitis Yes No

Asthma Yes No Gonorrhea Yes No Osteoporosis Yes No Tuberculosis Yes No

Bleeding Disorders Yes No Gout Yes No Pacemaker Yes No Tumors, Growths Yes No

Breast Lump Yes No Heart Disease Yes No Parkinson's Disease Yes No Typhoid Fever Yes No

Bronchitis Yes No Hepatitis Yes No Pinched Nerve Yes No Ulcers Yes No

Bulimia Yes No Hernia Yes No Pneumonia Yes No Vaginal Infections Yes No

Cancer Yes No Herniated Disk Yes No Polio Yes No Venereal Disease Yes No

Cataracts Yes No Herpes Yes No Prostate Problem Yes No Whooping Cough Yes No

Chemical High Cholesterol Yes No Prosthesis Yes No Other _____

Dependency Yes No Kidney Disease Yes No Psychiatric Care Yes No _____

0 EXERCISE

None

Moderate

Daily

Heavy

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

HABITS

Smoking

Packs/Day _____

Alcohol

Drinks/Week _____

Coffee/Caffeine Drinks

Cups/Day _____

High Stress Level

Reason _____

Are you pregnant? Yes No Due Date _____

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

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____) _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Elite Chiropractic and Wellness Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Elite Chiropractic and Wellness Center. I understand that diagnosis or treatment of me by Elite Chiropractic and Wellness Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Elite Chiropractic and Wellness Center is not required to agree to the restrictions that I may request. However, if Elite Chiropractic and Wellness Center agrees to a restriction that I request, the restriction is binding on Elite Chiropractic and Wellness Center and Dr. Staci Addressi.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Staci Addressi or Elite Chiropractic and Wellness Center has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Elite Chiropractic and Wellness Center’s Notice of Privacy Practices prior to signing this document. The Elite Chiropractic and Wellness Center’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Elite Chiropractic and Wellness Center. The Notice of Privacy Practices for Elite Chiropractic and Wellness Center is also provided on the wall. This Notice of Privacy Practices also describes my right and the Elite Chiropractic and Wellness Center’s duties with respect to my protected health information.

Elite Chiropractic and Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative’s Authority