Welcome! Please fill out this Patient Registration

Personal: *(Please Print Clearly, Sign ALL pages and be Complete)*

Last Name_____ First Name_____ Middle _____

Street _____ City_____ State_____ Zip_____

Home Phone #: (____) _____ Work / Cell Phone #: (____) _____

SS#_____-_____-_____ E-Mail: _____

Date of Birth _____/_____/_____ Sex: Male / Female Marital Status: Married / Single

Employer_____ Occupation_____

Spouse's Name _____ Spouse's Date of Birth _____/_____/_____

Emergency Contact _____ Ph: (_____) _____ Relationship: _____

Insurance: (*Please keep out your Insurance ID card and photo ID to be copied)*

Insurance Company _____ Phone # (_____) _____

Street _____ City_____ State_____ Zip_____

Policy #_____ Group #_____

Name of Insured_____ Date of Birth _____/_____/_____ SS# _____-_____-_____

Employer of the Insured_____ Relation (patient/insured): _____

Health History:

Please list your chief complaints: 1) _____ How long? _____

(In order of severity) 2) _____ How long? _____

3) _____ How long? _____

Have you ever had any complaints in the involved area before? Yes ☐ No ☐

Are you under the care of any other doctor? Yes ☐ No ☐ If Yes, what?_____

If yes, please explain: _____

Is your current condition related to work injury or auto accident? If Yes, when?

List past injuries & dates: _____

List past surgeries & dates: _____

Chiropractic History:

Have you ever been to a Chiropractor before? If Yes, Doctor's Name?_____

Date of last visit: _____ Reason for Care? _____

Date of last X-rays: _____ How long were you under care? _____

If you are Female, Could you be pregnant? Yes ☐ No ☐

Are other family members under Chiropractic care? Yes ☐ No ☐ If Yes, who?_____

How did you find out about Dr. Susan, please explain?

Advertisement?_____ Internet source? _____

Patient referral? _____ Doctor referral?_____

Friend / Co-worker?_____ Other? _____

What symptoms are you currently experiencing?

Chiropractic health care stresses the treatment of the *WHOLE* person, not just your back and neck.
To help us understand your health history, we ask that you fill out this questionnaire.

Symptoms Now	***Symptoms Now***
☐ Headaches	☐ Loss of Balance
☐ Neck Pain	☐ Fainting
☐ Back Pain	☐ Loss of Smell
☐ Trouble sleeping	☐ Loss of Taste
☐ Nervousness	☐ Cold Hands
☐ Tension	☐ Cold Feet
☐ Irritability	☐ Arthritis
☐ Chest Pain	☐ Muscle Spasms
☐ Dizziness	☐ Frequent Colds
☐ Shoulder/Arm/Neck Pain	☐ Upset Stomach
☐ Pins & Needles in Arms	☐ Constipation
☐ Pins & Needle in Legs	☐ Diarrhea
☐ Numbness in Fingers	☐ Cold Sweats
☐ Numbness in Toes	☐ Fever
☐ Weakness in the Arms	☐ Face Flushing
☐ Weakness in the Legs	☐ Sinus Problems
☐ High Blood Pressure	☐ Diabetes
☐ Difficulty urinating	☐ Leg Cramps
☐ Allergies	☐ Hemorrhoids
☐ Hay Fever	☐ Colitis
☐ Shortness of Breath	☐ Gall Bladder
☐ Fatigue	☐ Indigestion
☐ Depression	☐ Vomiting
☐ Light Bothers Eyes	☐ Knee Pain
☐ Loss of Memory	☐ Menstrual Problems
☐ Ringing in the Ears	☐ Positive for HIV or AIDS
☐ Buzzing in the Ears	☐ Positive for Hepatitis

If you marked Allergies above, allergic to what?_____

Have you lost or gained weight in the last year? Yes ☐ No ☐ If Yes, how much? _____**(+ / -)**

Do you take vitamins or herbs? Yes ☐ No ☐ If so, what type and how much? _____

_____

Do you Exercise? Yes ☐ No ☐ If so, what type and how much? _____

Who is your Primary Care Physician? _____

Where are they located? _____ **Phone:** _____

When was your last Physical Exam? _____ **Blood Workup?** _____

Patient's Signature: _____ PLEASE SIGN HERE

Electronic Health Records Intake Form

This form is repetitive but it complies with CMS EHR requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____ **DOB:** ____/____/_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Gender (Circle one): Male / Female **Preferred Language: English / other:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American

White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below) *Example: Heart Disease*	Father:	Mother: *X*	Sibling: Sister/Brother	Offspring: Daughter/Son

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	**Dosage and Frequency (i.e. 5mg once a day, etc.)**

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Enter Your Data: Height: ____feet____inches Weight: _____ Blood Pressure: _____ /_____

Patient Signature: _____ PLEASE SIGN HERE Date: ____/_____/____

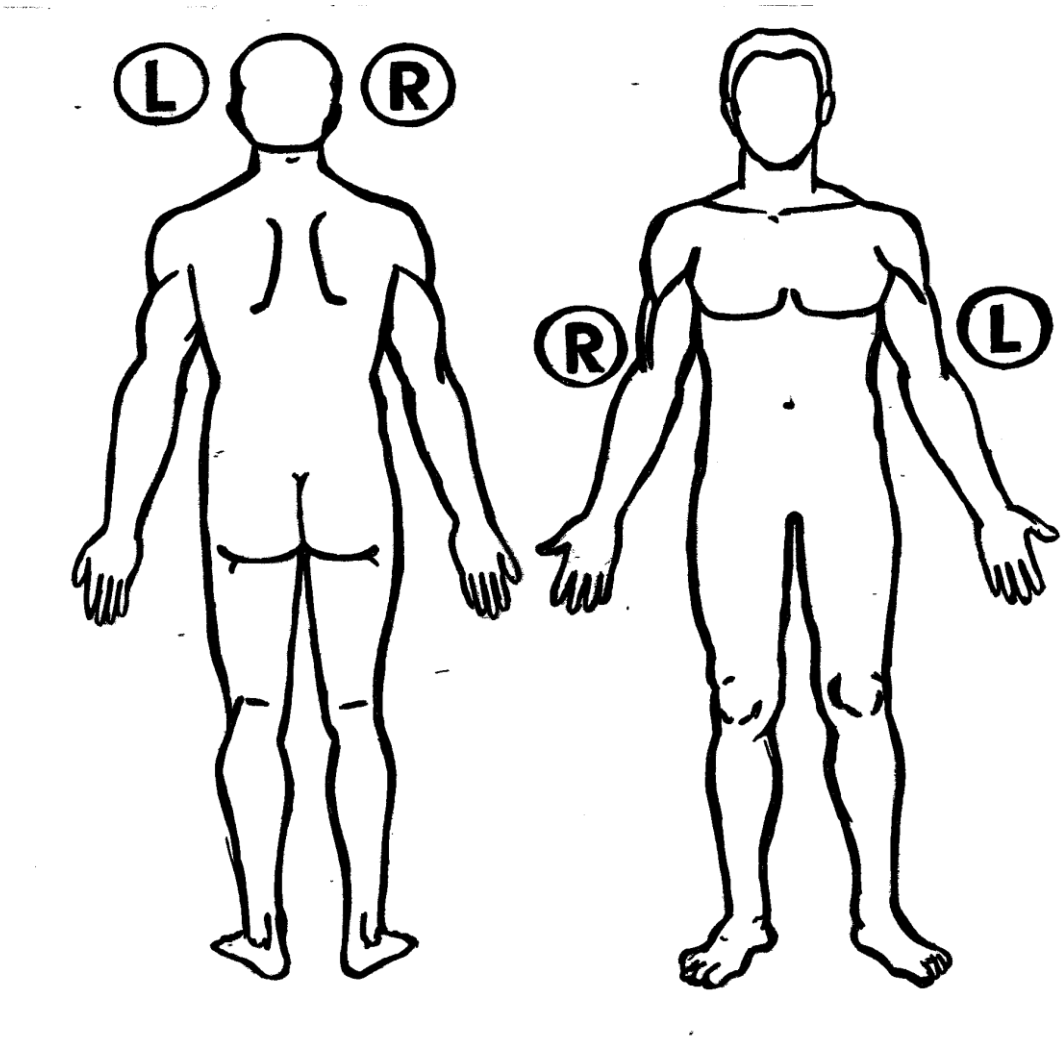
Current Pain Diagram

Name:_____ PLEASE SIGN HERE Date:_____

Mark all the areas of your body where you feel pain NOW.
Use the symbols below to describe the type of pain in the area of pain.

ACHE ####	NUMBNESS ====	PINS& NEEDLES oooo
BURNING xxxx	STABBING ////	OTHER ^^^^ (please describe)

Draw at the location of your pain TODAY



Rate the Pain You Have TODAY

0	1	2	3	4	5	6	7	8	9	10

No Pain **Severe Pain**

Consent for Use and Disclosure of Health Information

Our Privacy Pledge

We are very 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 use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you can request to be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

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 your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as 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.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment. You also are authorizing the use of communication through email using the email you provide in the demographic section of this paperwork.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your revocation. In addition, if you were required to give your authorization as 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.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. However, we will not be authorized to call you regarding appointments, treatment, or claim status information. If you would like to refuse this authorization, please **initial here:**

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of today. This authorization will expire seven years after the date on which you last received services from us.

I have read both the above policies and agree to its terms (unless initialed above). I am also acknowledging that I can, upon request receive a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

x _____ PLEASE SIGN HERE *x* _____

Patient Name Printed Personal Representative — Authorized Provider Representative

x _____ _____ _____

Signature — Date

Authorization & Assignment

In consideration of your undertaking to treat me, I agree to the following:

Medical Release

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred by me.

Assignment of Benefits

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event that any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such a payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due I personally owe you.

I, the undersigned do hereby appoint Dr. Susan Knight-Nanni authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with Dr. Susan Knight-Nanni when said payments are due to services rendered on behalf of the undersigned by the clinic.

A service charge of 1.5% per month will be charged on all accounts over 20 days past due. If placed out for collection or suit is brought on this account, I agree to pay reasonable attorney fees and collection costs.

A photocopy of this assignment shall be valid and have the same effect as the original.

x _____ 

x _____

Signature & Date

Authorized Provider Representative & Date

Please provide the names of people you wish to give permission for us to correspond with regarding you and your care (and relationship to you):

_____

_____

_____

Informed Consent for Chiropractic Care

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain temporarily
- No improvement of symptoms or pain
- Burns or frostbite (physical therapy)

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to receive treatment as seen appropriate for my diagnosis and at the discretion of the doctor. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
Print name

PLEASE SIGN HERE

_____
Signature of patient

_____
Date signed

To be completed by the patient's representative:

_____
Print name of patient

_____
Print name of patient's representative

_____As:_____
Signature of patient's representative Relationship to patient

_____
Date signed

To be completed by doctor or staff:

_____ _____
Witness to patient's signature date