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) _____

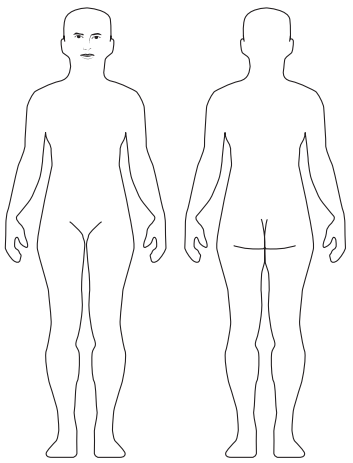
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

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 _____

Segebart Chiropractic, PLLC

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 (**PHI**) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their **PHI** for the purpose of treatment, payment, healthcare operations 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 purpose 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 understands and agrees that if the Health Insurance Company (or companies) allows a certain number of chiropractic visits per calendar year our office will do its best to obtain additional visits if needed. If the Health Insurance Company denies this request any additional visits will become the responsibility of the patient as a cash patient policy.
3. 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 may 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.
4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (**PHI**) will be used and I agree to these policies and procedures.

Name of Patient

Signature of Patient **Date**