Patient Registration

First_______________________________ **M.I.**_______ **Last**_____________________________ **Date**___________

Birth Date___________ **Preferred to be Called**_________________**Email**___________________________________

Address_____________________________________ **City**__________________ **State**_________ **Zip**_____________

Home Phone__________________________________ **Cell Phone**____

Gender: Male Female **Marital Status**: Single Married Widowed Separated Divorced

CMS requires providers to report both race/ethnicity and smoking habits

Race (circle one)**:** American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I decline to answer

Smoking Status (circle one): Every day Smoker Occasional Smoker Former Smoker Never Smoker

Emergency Contact____________________________ Phone___________________ Relationship_________________

Work:____ **Job Title**________________________________

Spouse ____ Spouse's Birthdate_____________________

Children (names, ages) ____

Are you here because you were in an automobile collision? Yes No If yes, when?________________________

Are you here because you were injured at work? Yes No If yes, when?_____________________________

Who is you Primary Care Physician? ________________________How did you hear about our office?________________

Have you ever received chiropractic care? Yes No If yes, When and Where?___________________________

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

Allergies			
Medication Name	Reaction	Onset Date	Additional Comments

Circle all that apply

General
Allergy
Dizziness
Fainting
Fatigue
Fever
Headache
Loss of Weight
Loss of Sleep
Depression
Numbness
Sweats

Respiratory
Chest Pain
Chronic cough
Difficult breathing
Wheezing

Muscle/Joint
Arthritis
Bursitis
Low back pain
Mid back pain
Neck pain

Pain or Numbness
Shoulders
Arms
Elbows
Hands
Hips
Legs
Knees
Feet
Painful tailbone
Poor posture
Sciatica
Spinal curvature

Skin
Bruise easily
Dryness
Hives or allergy
Itching
Skin eruptions (rash)

Gastro-Intestinal
Belching or gas
Colitis
Constipation
Diarrhea
Bloated abdomen
Gall bladder trouble
Hemorrhoids
Jaundice
Liver trouble
Nausea
Pain over stomach
Poor appetite
Ulcers

Genito-Urinary
Prostate trouble
Bed-wetting
Blood in the urine
Frequent urination
Kidney infection
Painful urination

Cardio-vascular
High blood pressure
Abnormal heartbeat
Swelling of ankles
Eye, Ear, Nose & Throat
Asthma
Loss of hearing
Earache
Sore throat
Enlarged glands
Nasal obstruction
Nose Bleeds
Sinus Infection
Sore throat
Enlarged glands

Women Only
Excess menstrual flow
Hot flashes
Irregular cycle
Lumps in breast
Menopause
Painful menstruation
Abnormal vaginal discharge

Are you pregnant? If yes, how long?________

Check any of the following conditions you currently have or have had

____ AIDS
____ Alcoholism
____Anemia
____ Cancer
____ Diabetes
____ Eczema
____ Edema
____ Emphysema
____ Epilepsy
____ Gout
____ Heart disease
___ Multiple Sclerosis
____ Pace maker
____ Pneumonia
____ Polio
____ Rheumatic fever
____ Stroke
____ Tuberculosis

Is there any other information you feel we might need for your care?

____
____
____
____

____
Patient Signature

HISTORY FORM

Patient Name: ____ Date:_________________________

Chief Complaint: ____

Began when and how?____

Have you had this pain before?____
____

Please circle the quality of the complaint/pain:dull aching sharp shooting burning throbbing deepnagging

Do you have any numbness or tingling in your body? Where?_____________________________________ ___________
____

How frequent is complaint present, how long does it last? ____

Is your compliant getting better, getting worse, or unchanged since it began? ___________________________________

Grade Intensity/Severity TODAY 0 1 2 3 4 5 6 7 8 9 10

Does anything aggravate the compliant?______________Does anything make the compliant better? _______________

Is there any daily activity you have difficulty with or can no longer do?
____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:
____

Past Health History

A. Previous illnesses you've had in your life: ____

B. Allergies: ____

C. Surgeries: ____

Family Health History

Associated health problems of relatives: ____

Social and Occupational History

Job physical demands: ____

Recreational activities: ____

Sleeping position: ____

Lifetyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _______________________________________

Office Financial Policy

Our Policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance**: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $150 at any time or care may be terminated.
2. **If You Have Insurance**: **All deductibles and co-payments are expected at the time of service or by an authorized payment plan.** You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. The office will attempt to find out what your insurance covers, but it is your responsibly to know your coverage.
   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and care in this area.
   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

____ **Authorization to release information**: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, adjuster, attorney, in order to process any claim for reimbursement of professional services rendered by you. I hereby release you of any consequence thereof.

____ **Assignment of Payment**: My insurance company and/or attorney are hereby requested to pay direct to the doctor(s) of this office, any monies due on my account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay my outstanding balance after my case is completed by the insurance company/attorney.

____ **Medicare Assignment**: I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my treating doctor of or directly to this office.

____ **Consent to care for a minor**: I hereby authorize the doctor(s) of this office to administer Chiropractic care as they deem necessary to my relative:_______________________________

I understand that I may be responsible for collections fees incurred if it becomes necessary to turn my account over to collections.

I acknowledge I have read and fully understand the above statements and agree to the terms outlined.

Patient Signature: ____ Date: __________________

Terms of Acceptance

When a patient seeks Chiropractic Health Care and is accepted into our office, it is essential for both parties to be working towards the same objectives. Chiropractic has one goal, to eliminate major interferences. It is important that patients understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation complex. Our chiropractic method of correction is by specific adjustment of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes altered nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we may recommend that you seek the services of your primary healthcare provider or a healthcare provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interferences to the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation through Chiropractic adjustments.

Consent for Purposes of Treatment, Payment & Healthcare

In compliance with HIPPA regulations, I acknowledge that Walsh Chiropractic & Wellness Center "Notice of Privacy Practices" has been made available to me.
I understand I have the right to review Walsh Chiropractic & Wellness Center Notice of Privacy Practices prior to signing this document. 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 Walsh Chiropractic & Wellness Center. My name, address, phone number and health care records may be used to contact me regarding appointment reminders, information about alternatives to my present care, or other health/office information that is available to me.
The Notice of Privacy Practices for Walsh Chiropractic & Wellness Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Walsh Chiropractic & Wellness Center's duties with respect to my protected health information.
Walsh Chiropractic & Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices at any time by request. I have the right to revoke this request, in writing, except to the extent that Walsh Chiropractic & Wellness Center has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge I have read and fully understand the above statements and I agree to the terms. All questions regarding the doctor's suggestions pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature ___________________________________ Date _______________

Printed Name ____________________________________