Sabin Chiropractic: Registration and History

1 PATIENT INFORMATION

Date_____

Patient_____

Patient Social Security _____

Address_____

_____

City State Zip

Email_____

Would you like to receive correspondence via e-mail? Y/N

Sex: ☐ M ☐ F Age_____ Birth Date_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Spouse's name_____

Birthdate_____Occupation_____

Whom may we thank for referring you?_____

_____

2 PAYMENT INFORMATION

__ Auto Insurance Claim __Commercial Insurance
__No Insurance (Self Pay)
__Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Sabin Chiropractic 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

3 PHONE NUMBERS

Home_____Work_____ Ext._____

Cell_____ Please Check Best number to Reach you

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

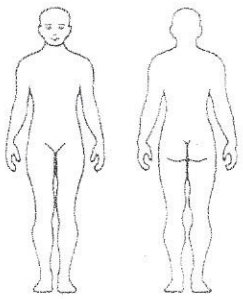
Phone_____ Alt Ph_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date_____
Type of accident __Auto __Work __Home __Other
To whom have you made a report of your accident?
__Auto Ins __Employer __Work Comp. __Other
Information for Auto Claims Only:
Name of Auto Insurance:_____
Claim #_____Ph #_____
Adjuster's Name:_____

5 PATIENT CONDITION

Reason for Visit_____
When did you symptoms appear?_____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an **X** on the picture for pain and mark **II** for numbness and/or tingling.
Please Rate the Severity of your pain on a scale from **1 (least pain) to 10 (severe pain)**
Pain Rating for Past 24 hrs: _____ Pain Rating for the Past Week: _____
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain? ☐ Constant ☐ Frequently (50-75% of the day)
☐ Occasionally (25-50% of the day) ☐ Intermittently (under 25% of the day)
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: _ Sitting _ Standing _ Walking _ Bending _ Lying Down
In general, would you say that your overall health is: _ Excellent _ Very Good _ Good _ Fair _ Poor
Patient Signature X_____ Date_____



6

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therpay
☐ Chiropractic Services ☐ None ☐other_____
Name and address of other doctor(s) who have treated 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 _____

Please place a mark to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Emphysema	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Miscarriage	☐ Scarlet Fever
☐ Allergy Shots	☐ Fractures	☐ Mononucleosis	☐ Stroke
☐ Anemia	☐ Glaucoma	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Appendicitis	☐ Goiter	☐ Mumps	☐ Thyroid Problem
☐ Arthritis	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Asthma	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Bleeding Disorders	☐ Hepatitis	☐ Parkinson's Disease	☐ Tumors/Growths
☐ Breast Lump	☐ Hernia	☐ Pinched Nerve	☐ Typhoid Fever
☐ Bronchitis	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ High Cholesterol	☐ Prostate Problem	☐ Whooping Cough
☐ Chemical Dependency	☐ Kidney Disease	☐ Prosthesis	Other_____
☐ Chicken Pox	☐ Liver Disease	☐ Psychiatric Care	_____
☐ Diabetes	☐ Measles	☐ Rheumatoid Arthritis	_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Drinks/Week_____
☐ Heavy	☐ Heavy Labor	☐ 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_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

People choose chiropractic care for a number of reasons. How long you decide to benefits from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.
___Relief Care ___Corrective Care ___Maintenance Care ___Check here if you'd like the Doctor to decide the best type for you

By my signature below , I authorize Sabin Chiropractic to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Sabin Chiropractic. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance.

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported the risk of serious complication approximate 1 in 1 million to 1 in 1.5 million. I authorize the doctor to diagnose and treat my condition as deemed appropriate, including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

SIGNATURE_____ DATE_____

IF MINORS, PARENT/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 **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 Patient Health Information (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 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.*

3. *A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.*

4. *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.*

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 protected.*

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 health care operations, the chiropractic physician has the right to refuse to give care.*

8. *From time to time we may send you birthday cards or letters use your name on a birthday list By your signature below you have given us permission to do so.*

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

_____ _____

Patient Name *Date*

_____

Patient Signature

Sabin Chiropractic