Affordable Chiropractic Registration and History

1 PATIENT INFORMATION

Date_____

Social Security #_____

Patient Name_____
(Last Name)

_____
(First Name) (Middle Initial)

E-mail_____

Address_____

City_____

State_____ ZIP_____

Sex ☐ M ☐ F Age_____

Birth date_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____Yrs

Employer _____

Employer's Address_____

_____

Work Phone (_____) _____

Parent/ Guardian _____ _____

Who may we thank for referring you? _____

_____

2 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_____

Birth date_____ 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))

Affordable 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 authorize the use of my signature on all insurance submissions.

The above-named clinic 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)

3 PHONE NUMBERS

Cell Phone (___) _____ Home Phone (____) _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship_____

Home Phone (___) _____ Work Phone (___) _____

4 FAMILY INFORMATION

Children's Name(s)	Sex	Date(s) of birth
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____

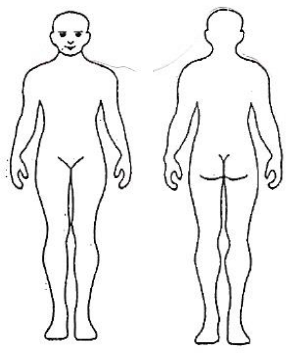
5 PATIENT CONDITION

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 ☐ Lyin

6 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 Problem	□ 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 Lumps	□ 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 Dependency	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No	Other: _____	

Injuries/Surgeries you have had: Description Date

Falls _____ _____

Head Injuries_____ _____

Broken Bones_____ _____

Dislocations _____ _____

Surgeries _____ _____

7 LIFESTYLE

EXERCISE	WORK ACTIVITY	HABITS	VALUES
□ None	□ Sitting	□ Smoking	Please list your interests in order of importance from 1-7 (1=most important)
□ Moderate	□ Standing	□ Alcohol	____Family ____Financial ____Social
□ Daily	□ Light Labor	□ Coffee/Caffeine	____Physical ____Mental ____Spiritual
□ Heavy	□ Heavy Labor	□ High Stress Level	____Work

8 MEDICATIONS

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone :(_____) _____

ALLERGIES

_____

_____

_____

_____

_____

VACCINATIONS

_____

_____

_____

_____

_____

AGREEMENTS AND AUTHORIZATION

CONSENT TO HEALTH CARE SERVICES/RELEASE OF HEALTH CARE INFORMATION

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Affordable Chiropractic. The Patient health care services will be provided by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals employed, under contract, or otherwise retained by Affordable Chiropractic. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

Signature _____
Date _____

PAYMENT GUARANTEE

In consideration of the services provided by Affordable Chiropractic, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Affordable Chiropractic, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Affordable Chiropractic. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered. By signing below I agree to the Payment Guarantee.

Signature_____
Date_____

MEDICARE

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. You authorize payment or authorized benefits to Affordable Chirpopractic on Patient's behalf.

Signature_____
Date _____

Please turn over and sign on back page

CONSENT TO RELEASE OF INFORMATION

You authorize Affordable Chiropractic to release to employer groups, government agencies, insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnoses and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Affordable Chiropractic for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Affordable Chiropractic or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, request Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Affordable Chiropractic is required, under Texas law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative.

Signature_____

Date_____

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Affordable Chiropractic for safekeeping under its sole care and custody

No revisions or changes to this form, by you, will be accepted by the Affordable Chiropractic.

_____ _____

Signature of Patient or Responsible Party (parent, guardian or other representative) **Date**

_____ _____

Signature of Policyholder **Relationship** **Date**

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment and Healthcare Operations

_____, hereby state that by signing this Consent I acknowledge and agree as follows: (Print Name)

1 The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2 The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3 The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at www.affordable-chiro.com. I may also request a copy from this office at any time via US Mail.

4 This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____	_____
Name of Individual (Printed)	Date Signed	Signature of Individual
_____	_____	_____
Signature of Legal Representative	Date Signed	Relationship
_____	_____	
Witness (Office Personal)	Date Signed	

REQUEST OF MEDICAL RECORDS

I, _____DOB_____, hereby request the release of my…

_____ X-Rays _____ Medical Records for the dates of service. I request

that they are sent to Affordable Chiropractic at:

4702 Northwest Highway Garland, TX 75043

Phone (972)270-5333 Fax (972)270-5335

Your cooperation in seeing that they are promptly returned will be greatly appreciated.

From: _____
_____
_____

and wish that they be sent to the address below, as soon as possible.

To: Dr. Dennis Williamson
4702 Northwest Highway
Garland Texas 75043
Phone: 972-270-5333
Fax: 972-270-5335

Sign:_____

Print:_____