CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ 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)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor 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

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work 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 ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

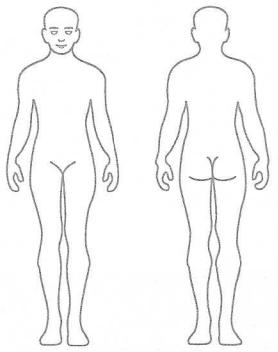
When did your symptoms appear? _____

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 ☐ Lying Down

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	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ 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

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

PATIENT INFORMATION

Name:_____ Date:_____

Height: _____ **Weight:** _____**lbs** **Blood Pressure:** _____ /_____

Pacemaker: **YES** **NO**

Smoking Status:

☐ Current every day smoker.....Started smoking in year: _____

☐ Current some day smoker.....Started smoking in year: _____

☐ Former smoker.....Started smoking in year: _____ Stopped smoking in year: _____

☐ Never smoker

☐ Heavy tobacco smoker.....Started smoking in year: _____

☐ Light tobacco smoker.....Started smoking in year: _____

Do you have any *MEDICATION* allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes...

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

CHIROPRACTIC HEALTH CENTER

FEE SHEET

PLEASE READ THE FOLLOWING AND MARK THE APPROPRIATE BOX.

We are required to process certain paperwork for particular types of billing cases. Please inducate which type of patient you are so that we can be thorough in handling your case.

( ) I believe I am a **CASH** patient. Cash patients are responsible for all of their charges and must pay for them at the time of service unless other specific arrangements have been made.

( ) I believe I am an **INSURANCE** patient. Insurance patients are responsible for all their charges. This office may or may not choose to bill your insurance company and accept assignment for payment towards your account. We must have a copy of your insurance card. After your insurance coverage has been verified, you will need to pay your deductible, co-payments and any charges not paid by your insurance company.

( ) I believe I am a **MEDICARE** patient. We must have a copy of your insurance card. You will be responsible for your annual deductible if you do not have a secondary policy.

( ) I believe I am a **WORK INJURY** patient. If a valid claim is not established, the patient is responsible for all charges.

( ) I believe I am a **PERSONAL INJURY** patient. Personal injury patients have usually been in an auto accident or have had a slip and fall type injury where someone else is liable for their medical charges. Extensive paperwork and documentation is needed; sometime lawyers are involved. If a valid claim is not established, the patient is responsible for all charges.

I understand that there is a fifteen ($15) dollar late fee and/or 18% interest that will be assessed on all dates of service that are 30 or more days past due and that I will continue to incur a fifteen ($15) dollar late fee every 30 days until the balance is paid in full. I agree to pay attorney fees and costs if legal action is required to collect for services.
I acknowledge that my medical records will be retained for seven (7) years from date of service. Any medical records older than seven (7) years may be destroyed.

I hereby give permission to the doctor to administer treatment and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient's Name _____ Date_____

Chiropractic Health Center
Dr. Alan S. Bader, D.C.
Dr. Micky R. Doyle, D.C.
294 East Moana Lane, Suite 28
Reno, NV 89502
Katrina Bader, Privacy Officer
(775) 829-7575

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient:_____

Date of Birth: _____

_____ _____
Signature of Patient Date

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Relationship (parent, guardian, power of attorney, etc.): _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

_____ _____
Signature of Personal Representative Date