RIGHTSPINE CHIROPRACTIC NEUROLOGY REGISTRATION

Date: ____________________ Phone: ________________________

Patient: ____
Last Name First Name Initial

Street Address: ____

City/State/Zip Code: ____

Sex: ☐ M ☐ F Age: ____ Birthdate: ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____________________ Email: ___________________________________

Insured's Name: ____
Last Name First Name Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ________________________________
Name of Insurance Company

and assign directly to **MARK D. FRIEDMAN DC,** all medical 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 my insurance submissions.

______________________________ ______________________
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: ____________________ **Medical alerts:** ____________________

Surgical Implants: ____________________ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: ____________________________________ Date: ______________

Doctor's Initials ________________

Medications: *(please list all medications and supplements that you currently take)*

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

Allergies: *(please list all medications that cause allergic reaction)*

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

Smoking: ___ Yes ___ No If yes, ______ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week ________

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery ________________________________ Date ________________
________________________________ ________________
________________________________ ________________
________________________________ ________________

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: ________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: ________________ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: ________________

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: ________________

Patient Name: ________________________________ Date: ______________

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type ______
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: ____________________

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: ____________________

Metabolic & Other Disorders

□ Diabetes x ________ years □ skin disorder ____________ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: ________________

Cancer : any type -- please specify

____

Other medical problems NOT included above (explain)

____

____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :________________________
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :__________________
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: ____________________
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :______________________
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify

____

Other medical problems NOT included above (explain)

____

____

Patient Name: ____ Date: ______________

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: ______________________________

Medicare/Medicaid Identification Number: ______________________________

Major Medical or Auto Insurance:

Date of Accident: ______________
Insurance Company Name: ______________________________
Adjuster: ______________________________
Address/Phone: ______________________________
Claim #: ______________ Policy #: ______________ Effective Date: ______________

Primary Care Physician:
Name & Address:

____

____

Phone #: ______________________________

LEGAL INFORMATION:

Attorney Name & Address:

____

____

Attorney Phone #: ______________________________

*Person to contact in an emergency (Name and Phone #):

____

Patient Name: ______________________________ Date: ______________

RIGHTSPINE CHIROPRACTIC NEUROLOGY

70 New Ocean St., Swampscott, MA 01907 PHONE: 781-581-7300 • FAX: 781-581-1190

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.
We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:______________________________ Date:__________

Print Name of Patient or Legal Guardian:____________________________ Date:__________