9 Maple Avenue Ext.
Uncasville, CT 06382
Phone: 860-848-8977
montvillechiropractic@outlook.com

Patient Registration Form

PATIENT INFORMATION:

Last Name: ____________ First Name:____________ Middle: ____ Date of Birth:___/___/___

Mailing Address:________________________ City____________ State:_____ Zip Code: ______

Sex: M F SSN:____________________ Marital Status: S M D W

Cell Phone: ____________ Cell Carrier: ____________ Home Phone:____________

Work Phone:________________________ Email:________________________

Primary Care Physician:________________________ Phone: ________________________

Who referred you to us?: Name: ________________ Relationship:____________

Parent/Guardian (who brings in the patient)

Last Name: ____________ First Name:____________ Middle: _____ Date of Birth:___/___/___

Mailing Address:______________ City: ______________ State:_____ Zip Code:______

PATIENT/PARENT EMPLOYER INFORMATION:

Employer Name:______________ Phone:______________ Occupation:____________

IS VISIT RELATED TO THE FOLLOWING: (please circle)

Auto Accident: Y N Workers' Compensation: Y N Other Accident: Y N

Explain:____

INSURANCE INFORMATION:

PRIMARY:_________________________________

SECONDARY:_______________________________

I give permission to discuss my medical condition, diagnosis and financial account with:

Name:________________________ Relationship: ____________ Phone #:____________

IN CASE OF EMERGENCY:

Emergency Contact Name:________________ Relationship: ________ Phone #: ____________

ASSIGNMENT OF BENEFITS

(Please read carefully and sign and date where indicated.)

ASSIGNMENT OF BENEFITS: I hereby assign medical benefits, to which I am entitled to: Montville Chiropractic. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

INSURANCE SIGNATURE ON FILE: I request that payment of authorized insurance benefits be made to me or on my behalf to Montville Chiropractic, for any services furnished to me. I authorize any holder of medial information about me to release to the HCFA and its agent any information needed to determine these benefits for related services.

Patient/Guardian Signature: ______________________________ Date: ______________

SELF-PAY (No Assignment of Benefits required): I attest that all the information I have provided on this form is correct, and that I will be paying out-of-pocket for all treatments received at Montville Chiropractic. I authorize any holder of medical information about me to release any information needed by Montville Chiropractic.

Patient/Guardian Signature: ______________________________ Date: ______________

PROTECTED HEALTH INFORMATION (PHI): I give permission to Montville Chiropractic to follow my instructions shown below regarding my PHI. The following PHI will remain in effect until revoked or revised by me in writing.

☐ Confirm appointment and /or leave message at ____ home ____ work ____ cell ____ text

____ Via person or ____ answering machine.

☐ I acknowledge receipt of Montville Chiropractic Notice of Privacy Practices.

☐ Patient declined Montville Chiropractic Notice of Privacy Practices: _____ Montville Chiropractic initials

EHR CERTIFICATIONS – INSURANCE MANDATED:

Ethnicity (circle one): Hispanic or Latino **OR NOT** Hispanic or Latino

Race (circle): White - American Indian/Alaskan Native - Asian - Black/African American

Native Hawaiian/Pacific Islander - Two or More:

Preferred Language (circle one): English - Spanish - French - Other___________________

PRIVACY POLICY:

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health insurance information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information with our practice for operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to certain individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information please let us know in writing. We are not required to agree to your restrictions.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing.

I have read your consent policy and agree to its terms. Initial______

INFORMED CONSENT TO CHIROPRACTIC TREAMENT

The nature of chiropractic treatment: The doctor will perform an examination if necessary, to determine a diagnosis and make treatment recommendations. If treated is initiated the doctor will use his/her hands or a mechanical device in an attempt to restore normal function to your joints and muscles. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation or other soft tissue techniques may also be used. Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare stiffness or soreness with the first few treatments. The ancillary procedures/hot packs could produce skin irritation, burns, or minor complications.

- Over-the-counter analgesics. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers or other side effects in a significant number of cases.
- Medical care prescription anti-inflammatory drugs, muscle relaxers and analgesics. Risks of these drugs include the above mentioned side effects ad patient dependence on narcotics.
- Surgery, in conjunction with medical care, adds the risks of adverse reaction to anesthesia, death, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite probable that a delay of treatment will complicate your condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

_________________ _____________

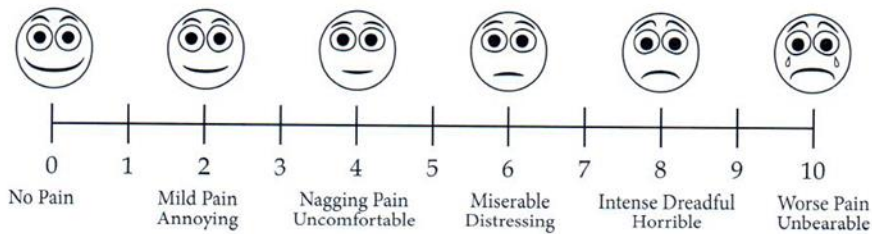
Signature Date

9 Maple Avenue Ext.
Uncasville, CT 06382
Phone: 860-848-8977
montvillechiropractic@outlook.com

List Prescribed Medications □ Check box if you are not taking any medication	**# of MD Refills issued**	**Quantity & Strength**	**Dose Form** (i.e. capsule)	**MD's Instruction** (i.e. 1 per day)

Are you Allergic to any Medicines? (please list) □ Check box if you have No Medical Allergies	**Describe Allergic Symptom:** (i.e. headache)

Have you been diagnosed with either of the following? **(Please Circle)**
Asthma? **Diabetes?**

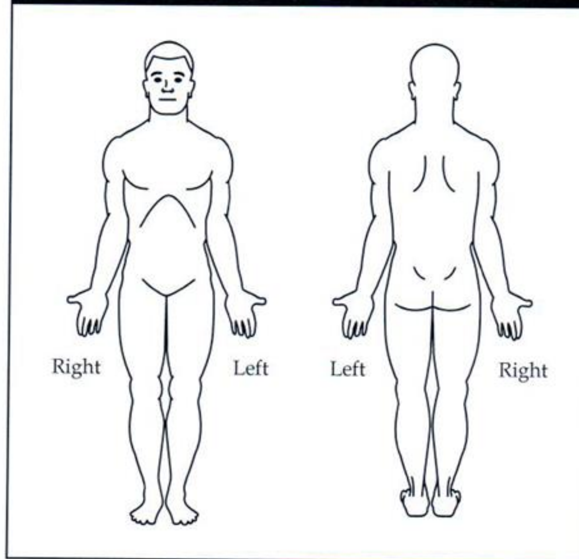


Using the pain scale above as a reference, please circle on the pain chart below from 1-10 the pain/discomfort you feel with this condition.

Pain Chart

	Better	Same	Worse	New
Neck/Headache Pain 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Shoulder, Arm Pain *R L* 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Mid Back Pain 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Low Back Pain 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Hip, Leg Pain *R L* 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Foot, Ankle Pain 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐
Other Pain __________________ 0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐

MARK AREAS OF PAIN ON FIGURES BELOW



Time of day when pain is worst: ____Morning ____Afternoon ____Evening ____Wakes Me ____Varies

Type of Pain: ____Stiffness ____Burning ____Numb/Tingling ____Sharp ____Soreness/Achy

Does the pain radiate: Yes No **Where?** ______________________________

Are your daily activities affected by these symptoms? Yes No

If yes, how? ______________________________

Please tell us what you've experienced since your last visit. Also, please describe any injuries/falls or what caused, changed or improved your symptoms

PATIENT NAME: ____________________ **DATE:** ____________

9 Maple Avenue Ext.
Uncasville, CT 06382
Phone: 860-848-8977
montvillechiropractic@outlook.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To All Physicians, Hospitals and Other Health Care Providers Who Have Provided Care, Treatment or Services and/or Insurance Companies Who Have Provided Benefits to ____________________________________:

I hereby authorize Montville Chiropractic, and persons acting on its behalf, to receive information, and examine and receive copies of all records of every sort and kind, regarding the medical status of the patient named below. Such information and records are required in order to evaluate the condition of the patient. A photocopy of this authorization is to be considered as effective and valid as the original.

I understand that the medical information and records disclosed pursuant to this authorization may be re-disclosed by the receiving entity for any lawful purpose, and thereafter, may no longer be protected by federal law privacy rules. I understand this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. However, I understand that any such revocation will not have any effect on any actions the providing entity took prior to receiving the revocation. If not earlier revoked, this authorization shall terminate upon settlement of all claims relating to the accident referred to above. Upon my request, I may see and copy the medical information described on this form.

__________________________________ __________________________________

Name Date

__________________________________ __________________________________

Social Security Number Date of Birth