

# 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) \_\_\_\_\_

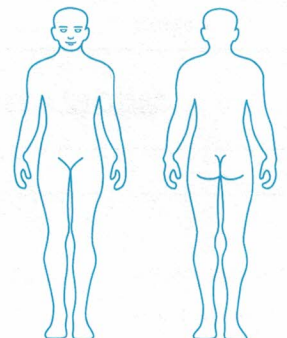
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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

## ALLERGIES

## VITAMINS/HERBS/MINERALS

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

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. Including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic who now or in the future treat me while employed by, working, or associated with, serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but limited to: fracture, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

To be completed by patient's representative. If necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Name of Patient's Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Patient's Representative

As \_\_\_\_\_  
Relationship or Authority of Patient's Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
To be completed by Doctor or staff:

Name and address of clinic/office:

**Bayside Chiropractic**  
**Dr. Leslie M Bryan**  
**11322 US Highway 31**  
**Daphne, AL 36527**

Print name(s) of doctor(s) treating this patient:

\_\_\_\_\_  
Dr. Leslie Bryan  
\_\_\_\_\_  
Dr. Timika Frazier

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date

Bayside Chiropractic  
Dr. Leslie M Bryan  
11322 US Highway 31  
Daphne, AL 36527

PLEASE PRINT

Name \_\_\_\_\_  
File# \_\_\_\_\_

*Telephone Communication Preferences*

<u>Location</u>	<u>Number</u>	<u>Can we call you here?</u>		<u>Can we leave a message?</u>	
Home	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Mail Communication Preferences - **PERSONAL OFFICE USE ONLY!***

May we send mail to your home address? (For example, Birthday Cards, Promotional Cards, Newsletters, etc)  
If no, please provide an Alternate mailing address below.  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other than you, your insurance company, and health care providers involved in your care, whom can we talk about your health care information? (Check all that apply)

	<u>Name</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse	_____	_____
<input type="checkbox"/> Caretaker	_____	_____
<input type="checkbox"/> Child	_____	_____
<input type="checkbox"/> Parent	_____	_____
<input type="checkbox"/> Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons?  
If so, please specifically describe the information and person or persons below:

\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

\_\_\_\_\_  
Patient or personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name Relationship to Patient

\_\_\_\_\_  
Relationship to Patient

# ASSIGNMENT OF BENEFITS & HIPAA RELEASE FORM

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical      ▪ Worker's Compensation      ▪ Medicaid      ▪ Medicare      ▪ Auto  
Accident      ▪ Medical Savings Account & Flex Plans      ▪ Other

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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 HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature Authorizing Care:

\_\_\_\_\_ Date: \_\_\_\_\_

*(for use by participating providers)*

**TO: Medicare Patients**

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. WE WILL FILE ALL MEDICARE CLAIMS.
2. WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.
3. WE ARE PARTICIPATING PROVIDERS WITH MEDICARE WHICH MEANS THAT MEDICARE PAYS US DIRECTLY, HOWEVER, MEDICARE PATIENTS MUST MEET AN ANNUAL DEDUCTIBLE, WHICH WE ARE REQUIRED TO COLLECT AT THE BEGINNING OF SERVICES FOR EACH CALENDAR YEAR. SUPPLEMENTAL COVERAGE MAY PAY THE DEDUCTIBLE BUT IF NO SUCH COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE.
4. MEDICARE PAYS FOR 80% OF ALLOWED CHARGES. SUPPLEMENTAL COVERAGE MAY PAY THE 20%, BUT IF NO COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE.
5. MEDICARE DOES NOT PAY FOR MAINTENANCE CARE. THIS WILL BE YOUR RESPONSIBILITY.
6. MEDICARE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.

**MEDICARE PAYS FOR:**

Manual manipulation of the spine  
-IF SUPPORTED BY X-RAY AND/OR EXAMINATION  
-After the deductible is met  
-Depending upon the condition

**MEDICARE DOES NOT PAY FOR:**

-Examinations  
-Physical therapy  
-X-rays  
-Nutritional supplements  
-Orthopedic supplies  
-Maintenance care  
-Rehab

If you have questions regarding these guidelines, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

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Signature of patient or person acting on patient's behalf

Date