# 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) ______________

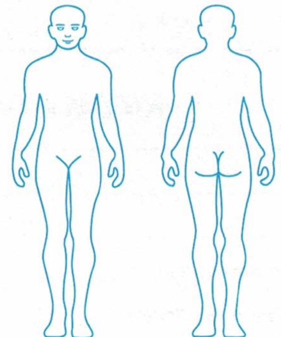
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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

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## 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:

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| Pharmacy Name ____________ | ____________ | ____________ |
| Pharmacy Phone (____)____________ | ____________ | ____________ |

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

PLEASE PRINT

Name ______________________________

File# ______________________________

*Telephone Communication Preferences*

| **Location** | **Number** | **Can we call you here?** | | **Can we leave a message?** | |
|---|---|---|---|---|---|
| Home | ____________ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Work | ____________ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Cell | ____________ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Other | ____________ | ☐ Yes | ☐ No | ☐ Yes | ☐ 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)

| | Name | Telephone |
|---|---|---|
| ☐ Spouse | ____________ | ____________ |
| ☐ Caretaker | ____________ | ____________ |
| ☐ Child | ____________ | ____________ |
| ☐ Parent | ____________ | ____________ |
| ☐ Other | ____________ | ____________ |

Do you have any health information that you would like to be kept confidenrial 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 are, 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 you medical records, please inform our office.**

Patient Signature:

________________________________________ Date:__________________

Guardian Signature Authorizing Care:

________________________________________ Date:__________________

## 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 an 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:

______________________________
Print Patient's Name

______________________________
Patient's Signature

______________________________
Date Signed

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

______________________________
Print Name of Patient

______________________________
Print Name of Patient's Representative

______________________________
Signature of Patient's Representative

As____________________________
Relationship or Authority of Patient's Representative

______________________________
Date Signed

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To be completed by Doctor or staff:

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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