Abbott Family Chiropractic

Registration and History

The human body is designed to be healthy. Throughout life, events occur which decrease your health expression. This form will help uncover why and determine what can be done to get you healthy again.

Patient Information

Date _____ ID#_____
(office use only)

Name

_____
Last First

Address_____

_____
City State Zip

Sex: ☐M ☐F Age____ Birthdate _____

Social Security # _____

☐Single ☐Married ☐Widowed ☐Divorced

Spouse's Name _____

Your Occupation _____

Your Employer_____

Whom can we thank for referring you to our practice? _____

Website Membership

Our website www.northvillechiropractor.com has many resources and articles to keep you well while you're away from the office. By providing the following details we can establish you as a member, and you authorize us to send you occasional wellness related emails. Of course, you can opt-out at anytime.

Your email address:

_____

Subjects of interest:

□ Headaches & Neck Pain
□ Backaches & Sciatica
□ Children's Health Issues
□ Exercise & Fitness
□ Diet & Nutrition
□ Stress Management
□ Wellness Topics
□ Women's Health

Phone Numbers

Home _____
Cell _____
Work _____
Best time and place to reach you

_____
Name & Location of Primary Care Physician

_____
PCP's Phone Number _____
IN CASE OF AN EMERGENCY, CONTACT
Name_____ Relation-ship_____
Phone_____

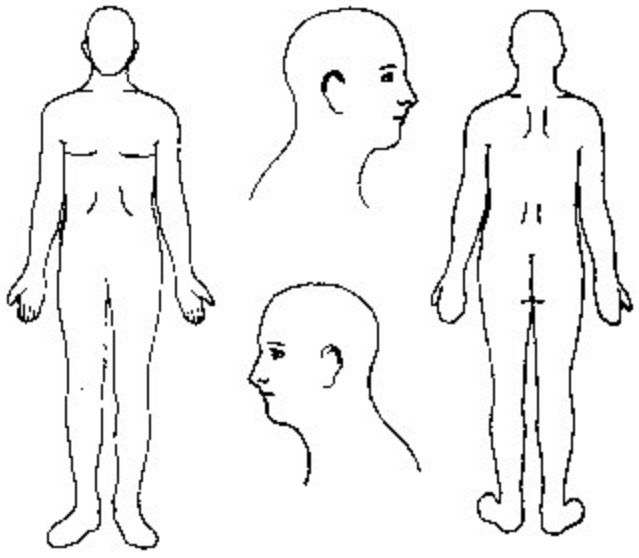
Patient Condition

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

S = STABBING
N = NUMBNESS
B = BURNING
A = ACHE
P = PINS & NEEDLES



Pain Scale

Please circle the number that describes your pain

0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Health History

Have you previously received chiropractic care anywhere else? ☐Yes _____ ☐No

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐ Physical Therapy

☐Chiropractic Services ☐None ☐Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____ Blood Test _____

MRI, CT-Scan, Bone Scan _____

Please check symptoms you currently have:

☐Balance Impairment	☐Headaches	☐Memory Loss	☐Vertigo
☐Burning Eyes	☐Lightheadedness	☐Nausea	☐Visual/Sensory Disturbance
☐Depression	☐Concentration Loss		☐Ringing/Buzzing in Ears

Please Check conditions you currently have or have had in the past:

☐Aids	☐Cataracts	☐Herniated Disk	☐Parkinson's Disease	☐Tuberculosis
☐Anemia	☐Chemical Dependence	☐Herpes	☐Pinched Nerve	☐Tumors, Growths
☐Anorexia	☐Diabetes	☐High Blood Pressure	☐Pneumonia	☐Ulcers
☐Appendicitis	☐Emphysema	☐High Cholesterol	☐Polio	☐Varicose Veins
☐Arthritis	☐Epilepsy	☐Jaw Pain/ TMJ	☐Prosthesis	☐Whiplash
☐Asthma	☐Glaucoma	☐Kidney Disease	☐Psychiatric Care	
☐Blood Clots	☐Goiter	☐Liver Disease	☐Rheumatoid Arthritis	
☐Breast Lump	☐Gout	☐Mononucleosis	☐Rheumatic Fever	
☐Bronchitis	☐Heart Disease	☐Multiple Sclerosis	☐Scarlet Fever	
☐Bulimia	☐Hepatitis	☐Osteoporosis	☐Stroke	
☐Hernia	☐Pacemaker	☐Thyroid Problems		

Anything Else:

EXERCISE

☐None ☐Daily
☐Moderate ☐Heavy

_____
_____
_____
_____

WORK ACTIVITY

☐Sitting (how many hours/day?) _____
☐Standing (how many hours/day?) _____
☐Heavy Labor **(briefly describe)**
_____
☐Light Labor **(briefly describe)**
_____

LIFESTYLE

Smoking Packs/Day _____
Coffee/Caffeine Cups/Day _____
Alcohol Drinks/Week _____
High Stress level Reason(s)

_____
_____

Injuries/ Surgeries	Description	Date
Accidents/Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____

MEDICATIONS (name, dosage, reason for taking)	VITAMINS/SUPPLEMENTS	ALLERGIES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Abbott Family Chiropractic Patient-Doctor Financial Agreements

Insurance Billing

This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged. This office will verify and bill a patient's insurance as a courtesy, but in truth it is the patient's basic responsibility. Insurance companies do not always pay the full amount of the patient's bill, even when the treatment is authorized and the insurance company has claimed that the treatment would be covered in full. The patient understands and agrees that s/he is ultimately responsible for all bills incurred at this office. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

_____ Patient's Initials

Non-Insured

We request 100% of the first visit be paid at the time of the first visit. All future visits must be paid for at the time of service. If your financial situation requires special arrangements, please speak with us.

_____ Patient's Initials

Missing or Changing Appointments

The doctor assigns a specific course of treatment for each patient. In order for patients to receive the maximum benefit from chiropractic care; it is important to adhere to this schedule. Therefore, if the patient misses or cancels an appointment, it is important to make up that missed appointment within the next few days. Twenty-four hour notice is required for changes and cancellations. If an appointment is missed, the patient may be charged a $50 fee for each 15 minutes scheduled.

_____ Patient's Initials

Payment of Bills

As a condition of treatment, payment is expected at time of service unless written financial arrangements are made and signed with this office. A finance charge of 4.2-5% per month is added to unpaid balances at 30 days after the patient is billed. If no payments are received within a 90 day period, collection action will commence, and I agree to pay all legal and bookkeeping fees associated with collecting my unpaid delinquent balance.

_____ Patient's Initials

Communication

We are here to serve you. Please speak with us about any concerns that may arise at any time. By communicating how you are experiencing care in our office, you enable us to provide you with the best possible service.

_____ Patient's Initials

The Nature of Chiropractic

Chiro means "hands," so chiropractic is the art of healing with the hands. This means that the doctor may palpate and adjust all areas of the spine, from the neck to the sacrum. Because everyone has unique comfort levels with his/her body and with being touched, please keep an open communication with us regarding your own comfort level. There are multiple ways to adjust you and with your feedback, we can find the technique with which you are most comfortable.

_____ Patient's Initials

I hereby agree to the above and give my consent to undergo examination, x-ray evaluation, and chiropractic care if recommended.

_____ _____

Signature Date

_____ Office Staff (Initials)

Our Privacy Pledge

At Abbott Family Chiropractic, we use "Open Room Adjusting" in which you will often be treated while other patients are in the clinic. We have found this arrangement has many benefits for our patients. It allows us to greatly shorten waiting time (most days you will not have to wait at all) and the Doctor's advice on healthy living is beneficial for all to hear. Personal or embarrassing topics will not be discussed in this open forum but anything you discuss with the doctor can and will be overheard by other patients.

If you wish to discuss a private matter with the doctor, please notify Kate so that you may be seen separately. It is not necessary for you to tell her the subject of this discussion.

We have a separate room to adjust those patients that do not want to participate in Open Room Adjusting. Please note that , if you make this choice, you may have to wait longer to see the doctor and your choice of appointment times may be limited. If you wish to be adjusted away from the Open Adjusting Room, please notify the team member at the front desk for special accommodations.

We are very concerned with protecting your privacy. 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 care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for 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 you health information within our practice for quality control or other operational purposes.

You have the right to review our privacy notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

_____ _____

(printed name) (authorized provider representative)

_____ _____

(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

(signature) (date)