CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

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

3 PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 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) _____

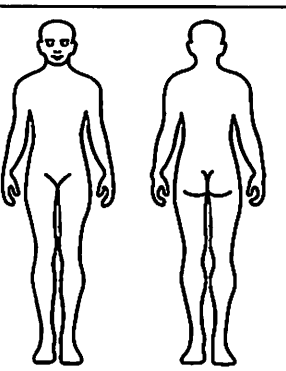
5 PATIENT CONDITION

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

6 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	☐ 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		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
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		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

ChiroCentric, L.L.C.
Kimberly DeAlto, D.C.
12620 SW 3rd Street
Beaverton, OR 97005
(503) 430-7371

OFFICE POLICIES

To prevent any misunderstandings about your insurance coverage and my billing/collections procedures, I would like to inform my patients that I could not render services on the **ASSUMPTION** that my charges will be paid by an insurance company. You will be fully responsible for all professional services furnished that your insurance company does not pay. Benefits given by your insurance company, over the phone, are quotes of coverage and not absolute coverage.

As a courtesy to my patients, I will bill your insurance company and benefits will be assigned directly to this office. **YOU ARE RESPONSIBLE** to know what your insurance covers prior to me calling. It is the policy of this office to:

1. Receive full payment for services rendered from patient paying at the time of service (Cash, Check, or Credit Card). When you pay at the time of service you get a 20% discount. If you wish to be billed later you will be billed at my regular rate. If you wish to see a list of my rates please ask and the office will supply you with those details.
2. Collect insurance co-payments on the same day services are rendered.
3. A $55 cancellation fee may be applied if given less than 24 hours notice of a cancelled or no show for a Chiropractic appointment.
4. Bill a 10% delinquency charge if payment is not received prior to the next monthly billing. (Any bill over 30 days late)
5. A $30.00 fee will be charged for all returned checks.
6. In some cases your insurance company will send you the check for services rendered in this office. You agree, upon receipt of a check, that you will endorse it and send it/deliver it to my office with the Explanation of Benefits attached. You are responsible to pay your balance within 30 days of when service is rendered whether it be a check from your insurance company or a personal account.
7. There is no refund on orthotics after the 45 day break in period.

Please sign and date this policy form. Your signature will signify your understanding and compliance with ChiroCentric Office Policies.

Signature_____

Date_____

ChiroCentric, L.L.C.
Kimberly DeAlto, D.C.
12620 SW 3rd Street
Beaverton, OR 97005
Telephone: (503) 430-7371

INFORMED CONSENT TO CHIROPRACTIC CARE

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the above named doctor of chiropractic.

Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of health care, there are some risks. These can include but are not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have had the opportunity to discuss with the doctor the purpose, benefits and risks of the recommended chiropractic care and alternatives to chiropractic treatment have been reviewed.

I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made. I have had ample opportunity to ask questions and my questions have been answered to my satisfaction.

Patients name (Printed) _____ Date _____

Signature of Patient: _____

OR

Signature of Parent/Guardian _____
(If patient is a minor)

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Eligibility Guarantee:

I, _____ herby certify that I am eligible for Chiropractic benefits offered by my insurance either provided by myself, employer, spouse or auto.

I understand that if the above is not true, or if I am not eligible under the terms of my Medical/Hospital Subscriber agreement, or Insurance Policy, that I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above noted Health Plan.

I also understand that under this policy I am responsible for whatever portion my insurance company does not pay, including the yearly deductible (If applicable to my insurance plan).

Assignment of Benefits:

I authorize the release of any health information necessary to process this claims. A photo copy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the Chiropractor listed above who accepts assignment.

_____ _____

Date Signature of Patient (or subscriber)