ALLIED SPINE & SPORTS
CHIROPRACTIC
RELIEVE • RESTORE • RECOVER

PATIENT REGISTRATION

TODAYS DATE _____/_____/_____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ | Social Sec: _____ | Gender: ☐ M ☐F ☐ Other

Email: _____

Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Jewish Decent
☐ European ☐ Native American ☐Eskimo ☐ Other_____

☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Widowed ☐ Same Sex Relationship (____ years partnered)

Employer of Patient:_____Patient occupation:_____Phone: _____

Emergency contact: _____ Phone: _____

Whom may we thank for referring you? _____

INSURANCE ACCOUNT HOLDER INFORMATION

- If you ARE NOT presenting a card at time of appointment, please fill out ALL of the following information
- If you ARE presenting a card at time of appointment, please fill out the following **BOLDED** information if the patient is not the policy holder

PRIMARY INSURANCE:	**ACCOUNT HOLDER:**
INSURANCE ID#:	GROUP/PLAN #:

ACCOUNT HOLDER ADDRESS: _____
(if different from patient)
CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: ☐**SELF** ☐**CHILD** ☐**SPOUSE** ☐ **OTHER**	**ACCOUNT HOLDER DATE OF BIRTH: ____/_____/_____**

Employer of Account Holder: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

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PATIENT AUTHORIZATION

By signing this document I hereby agree and understand that the following:
(Check any/all that apply- READ CAREFULLY)

AUTHORIZATION FOR PAYMENT, MEDICAL RECORDS RELEASE AND MEDICAL COMMUNICATION

- ❑ I have willingly sought care and opinion and have consented to his treatment and recommendations.
- ❑ I attest that all the information that I have written and stated for the doctor is accurate to the best of my knowledge.
- ❑ I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.
- ❑ I hereby authorize my records to be: ☐ Sent to, and/ or ☐ Sent from, **ALLIED SPINE & SPORTS CHIROPRACTIC** to be used explicitly for the purpose of securing medical, legal or payment processes.
- ❑ I attest that I am aware that ***not all procedures and costs*** associated with my treatment and condition will be covered by insurance and that I am financially responsible for all charges whether or not paid by insurance. I will be responsible for the remaining costs. I assign directly to **ALLIED SPINE & SPORTS CHIROPRACTIC** all medical payments, if any, otherwise payable to me for services rendered.
- ❑ I authorize **ALLIED SPINE & SPORTS CHIROPRACTIC** to email me information regarding my (Circle any/all that apply):

  CONDITION | TREATMENT | INFO ARTICLES | ANNOUNCEMENTS | PRODUCTS | NEWSLETTERS

- ❑ I authorize **ALLIED SPINE & SPORTS CHIROPRACTIC** to communicate with me over: (Circle any/all that apply)

  POSTAL MAIL | EMAIL | HOME # | CELL # | WORK # | TEXTING | SOCIAL NETWORKING

- ❑ I authorize ***medical treatment of a minor*** for Dr. _____ to treat my son/daughter _____ as deemed necessary.

Patient Signature:_____ Date: _____

Guardian Signature:_____ Date: _____

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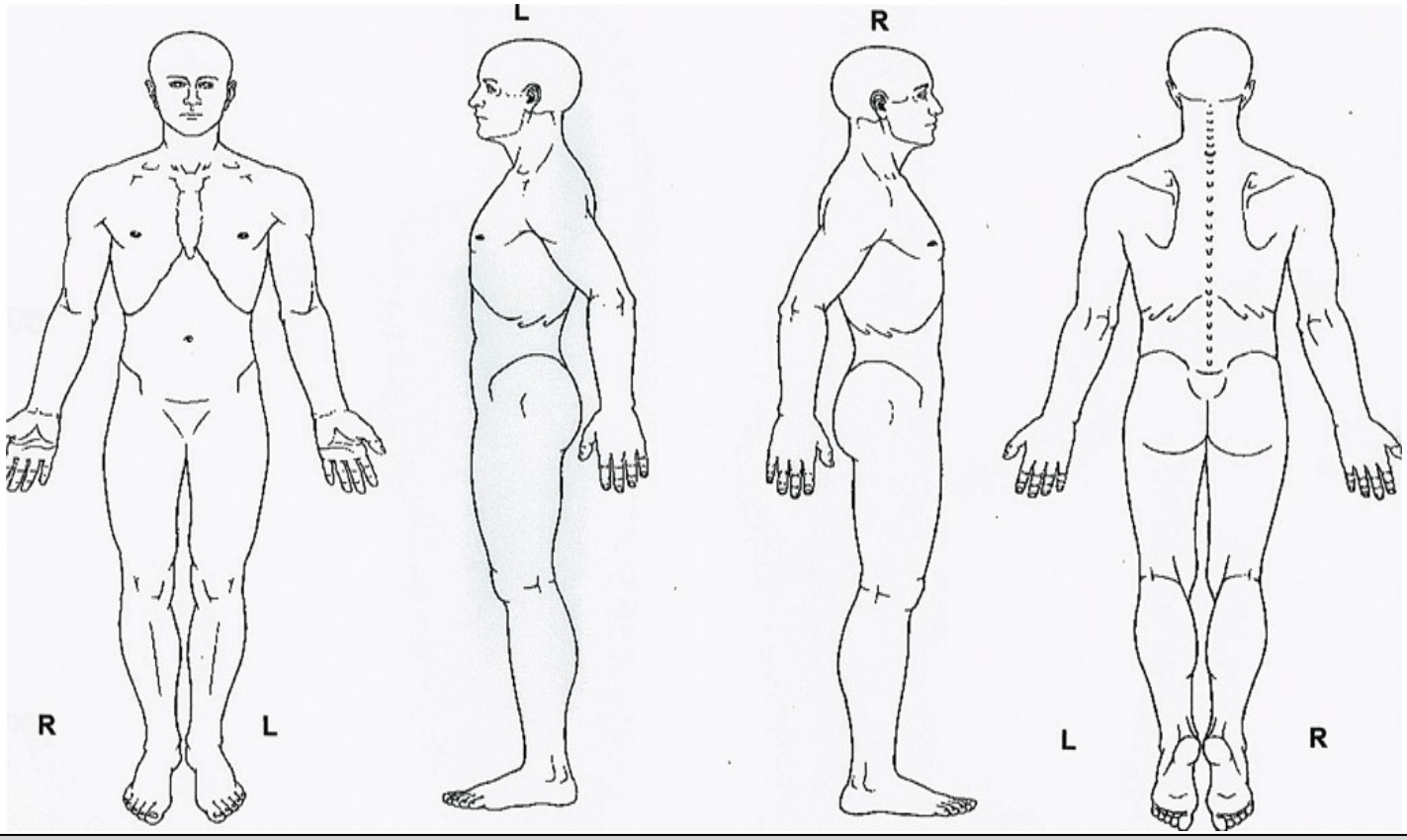
PATIENT SYMPTOM CHART

Mark the areas on the person that represent your symptoms.

Include <u>all</u> affected areas. Please use the appropriate symbols:

/////=Stabbing •••••=Burning ++++= Aching VVVV=Numbness >>>>=Throbbing XXXX=Pain



PATIENT CONDITION

When did your symptoms appear?

Rate the intensity of your symptoms: 1(least) to 10 (Worst) on average:____/10 at best:____/10 at worst:____/10

Reason(s) for visit?

How did this happen?

My condition feels **better** when I:_____	Is your condition getting worse? *Yes No Unkn*
My condition feels **worse** when I:_____	Is it: *Constant* or *Come and Go?*

It is painful when I: *Cough* | *Sneeze* | *Laugh* | *Bowel Movement*

What is your goal for treatment?

Type of Pain/Symptom (circle anything you have felt):

SHOOTING | *SHARP* | *DULL* | *ACHING* | *THROBBING* | *BURNING* | *TINGLING* | *CRAMPING* | *STIFFNESS* | *SWELLING* | *NUMB*
*OTHER*_____

This interferes with: *WORK* | *HOME* | *DAILY ROUTINE* | *SLEEP* | *RECREATIONAL ACTIVITIES* | *OTHER*_____

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PATIENT MEDICAL HISTORY

NAME OF HEALTH CARE PRACTIONER	Most Recent Appt Date	GROUP /FACILITY	PHONE
1.Primary Care:			
2.OB/GYN:			
3.Oncologist:			
4.Cardiologist:			
5.Orthopedist:			
6.Chiropractor:			
7.Physical Therapist:			
8.Acupuncturist:			
9.Massage Therapist:			
10.Personal Trainer:			
11.Other:			

ALLERGIES: (list all Product-latex, Drug, Food, Sensitivities)

MEDICATIONS / DOSAGE / USED FOR PRESCRIBING DOCTOR (list all)

SURGERIES

MOTOR VEHICLE ACCIDENTS / DATE

VITAMINS / MINERALS / HERBS / SUPPLEMENTS

PRESCRIBED BY: SELF, NUTRITIONIST, CHIROPRACTOR, MEDICAL, ACUPUNCTURE

Habits: Please check any of the habits below which apply to you now or in the past:

TOBACCO USE:

_____ # of cigarettes/day _____ # of packs/day ____ Age began smoking Stopped _____ years / months / days ago

ALCOHOL CONSUMPTION:

_____ # of drinks/week _____ Age began drinking Stopped _____ years / months / days ago

CAFFEINE CONSUMPTION:

_____ # of coffees/day _____ # of teas/day _____ # of colas/day Stopped _____years /months / days ago

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PATIENT HEALTH REVIEW

GENERAL

Cancer Type_____
Diabetes: Type I II How Long_____
Heart Disease_____
Stroke_____
Transient Ischemic Attack (TIA)_____
Headaches_____
Migraines_____
Insomnia_____
Depression_____
Fatigue_____
Psychiatric Counsel_____
Psychological Therapy_____
Aversion to Heat_____
Aversion to Cold_____
Thirst_____
Overall Feeling_____

MUSCLE AND JOINT

Joint Disorder_____
Spinal Disorder_____
Neck_____
Thoracic_____
Lumbar_____
Arms/ Hands_____
Legs/ Feet_____
Pelvis_____
OsteoArthritis_____
Rheumatoid Arthritis_____
Inflammatory Condition_____
Herniated Disc_____
Pinched Nerve_____
Scoliosis_____
Tendonitis_____

RESPIRATORY

COPD_____
Emphysema_____
Wheezing_____
Chronic Phlegm_____
Chronic Cough_____
Productive Cough: Phlegm / Blood
Frequent Colds_____
Asthma: Regular | Allergies | Exercise

REPRODUCTIVE

Discharge_____
Itching/Pain_____
Lumps_____
Infections_____
Pap Smear_____
Menstrual Periods_____
Menarche_____
Incontinence_____

SKIN

Hives_____
Rashes_____
Eczema _____
Night sweating _____
Excess sweating _____
Bruise easily_____
Changes in moles or lumps_____
Other_____
_____

GASTROINTESTINAL

Nausea_____
Indigestion_____
Stomach Pain_____
Diarrhea_____
Constipation_____
Bloody/black stools_____
Gallbladder disorder_____
Change in Weight_____
Food Cravings_____
Other_____
_____

NEUROLOGICAL

Pain_____
Numbness_____
Tingling_____
Burning_____
Tremors_____
Seizures_____
Headaches_____
Paralysis_____
Impairment_____
Other_____
_____

INFECTIOUS CONDITIONS

Oral Ulcers/Canker Sores____
Genital Herpes_____
Rashes_____
HIV_____
Blood Transfusions <1985 ____
STD_____
Chicken Pox___ Mumps _____
Measles____ Rubella_____
Tuberculosis_____
Other_____
_____

PATIENT FAMILY MEDICAL HISTORY

Please complete for each family member. Place an X in the box indicating the illness.

	FATHER	MOTHER	SPOUSE	SIBLING	SIBLING	SIBLING	CHILD	CHILD	CHILD	PATIENT
Allergies										
Blood										
Diabetes										
Cancer or Tumors										
Seizures										
High Blood Pressure										
Kidney or Bladder										
Stomach or Intestinal										
Drug Abuse										
Tuberculosis										
Heart Disorder										
Stroke										
Headaches / Migraines										
Liver Disorder										
Age at Death										
Other										

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HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Allied Spine & Sports Chiropractic** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Allied Spine & Sports Chiropractic** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Allied Spine & Sports Chiropractic** to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for **Allied Spine & Sports Chiropractic** to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: (315)498-6888; or visit HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation. If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**