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) _____

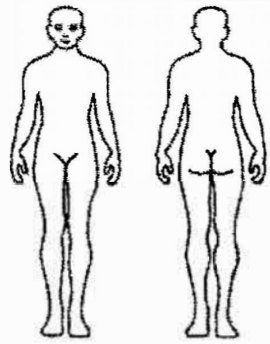
5 PATIENT CONDITION

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	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		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Electronic Medical Records Update Form

Today's Date: _____ Signature of Patient: _____

First Name: _____ Last Name: _____

Race (check one)

☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native
☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian or other Pacific Island
☐ Samoan ☐ Guamanian or Chamorro ☐ Other _____ ☐ I choose not to specify

Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Choose not to specify

Preferred Language *(check one)*

☐ English ☐ Spanish ☐ American Sign Language ☐ Chinese ☐ French ☐ German
☐ Tagalog ☐ Vietnamese ☐ Italian ☐ Korean ☐ Russian ☐ Polish
☐ Arabic ☐ Portuguese ☐ Japanese ☐ French Creole ☐ Greek ☐ Hindi
☐ Persian ☐ Urdu ☐ Gujarati ☐ Armenian ☐ I choose not to specify

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke? ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of Interest In quitting smoking?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NOT INTERESTED VERY INTERESTED

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No

If yes, describe:

_____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0 ☐ Yes ☐ No ☐ Not sure

If yes, other comments regarding Diabetes:

_____

Have you have an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

TO BE PERFORMED BY CLINIC STAFF:

HEIGHT: _____ RESISTANCE: _____

WEIGHT: _____ REACTANCE: _____

BP: ____ /____ ACTIVITY LEVEL: ☐ light ☐ moderate ☐ heavy

1141 E. MAIN STREET, SUITE 213 EAST DUNDEE, IL 60118
P: 847-551-5453 F: 847-551-5340 INFO@DRWILLOBRIEN.COM DRWILLOBRIEN.COM

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME: _____ SOCIAL SECURITY #: _____

I request and authorize _____

to release healthcare information of the patient named above to: _____

_____

_____

(NAME, ADDRESS, PHONE NUMBER)

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition, or dates

  _____

- o All healthcare information
- o OTHER

- o YES
- o NO

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

PATIENT SIGNATURE: _____ DATE SIGNED: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

CENTER *for* CHIROPRACTIC & NATURAL MEDICINE

Consent For Purpose of Treatment, Payment and Healthcare Operations

I, _____ (Name of Individual) consent to Center for Chiropractic & Natural Medicine ("CCNM") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

CENTER for CHIROPRACTIC & NATURAL MEDICINE

CANCELLATION & NO-SHOW POLICIES

Please understand that Center for Chiropractic & Natural Medicine does not over book our schedule to cover for patients cancelling at the last minute or not showing up. We reserve your appointment time for you specifically.

If you cancel on short notice, do not show up, or show up very late – that is lost opportunity that another patient could have used to be treated and lost revenue for the practice.

We understand unanticipated events happen occasionally in everyone's life, but in our desire to be fair to all patients and maintain a viable practice, the following policies are honored.

CANCELLATIONS

24-hour advanced notice is required when cancelling any appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged a $30 Fee for missing your appointment. This fee will be added to your account.

NO-SHOWS

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "No-Show" and will be charged a $30 Fee for their missed appointment. This fee will be added to your account.

LATE ARRIVALS

If you happen to arrive late for an appointment, your visit will likely be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours.

Depending upon how late you arrive, your doctor will have to determine if there is enough time remaining to start your treatment.

Out of respect and consideration for your doctor and other patients please plan accordingly and be on time.

_____ _____

PATIENT SIGNATURE DATE