Patient Registration Information

Name: _____ _____ ___ _____
Last name **First name** **Initial** **Date of Birth**

Street Address: _____ (Apt # ____)

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Would you like reminders by text message? ☐ Yes ☐ No If yes, cell phone provider: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

E-Mail: _____ Employer/Name of School: _____

PATIENT'S/ RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Other (if self, see above information)

Phone number: (_____) _____ Social Security #:_____-_____-_____

Address: (if other than above) _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

PATIENT'S REFERRAL INFORMATION Referred by: _____

If referred by a friend, may we thank them? YES NO Name_____

EMERGENCY CONTACT Name of person not living with you: _____

Relationship: _____ Address: _____

City: _____State: _____ Zip: _____ Phone number (home): (_____)_____

Phone number (work or cell):(_____)_____

I certify that the above information is correct and I request services.

Cancellation Policy

Due to the increase of "no shows" and late cancellations, we have had to institute a missed-appointment policy. We ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. Failure to give 24-hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of $30.00 to your account. Your cooperation and consideration are appreciated.

Your Signature: _____

Date: _____ Parent's Signature (if minor) _____

NAME: _____ **DATE:** _____

PLEASE IDENTIFY THE SYMPTOMS YOU HAVE: Any items that don't apply should be left blank.

HEAD:
_____ Headache
_____ Head Feels Heavy
_____ Sensitive to Light
_____ Blurred / Double Vision
_____ Loss of Smell / Taste
_____ Loss of Balance
_____ Loss of Hearing
_____ Pain in Ears
_____ Ringing / Buzzing in Ears

JAW:
_____ Pain
_____ Grind Teeth While Sleeping
_____ Clicking / Popping
_____ Fatigue With Chewing
_____ Locking (Open / Closed)

NECK:
_____ Neck Pain / Stiffness
_____ Neck Pain with Movement

SHOULDERS:
_____ Pain in Shoulder Joint (R / L)
_____ Pain Across Top of Shoulders

ARMS & HANDS:
_____ Pain in Upper Arm
_____ Pain in Elbow
_____ Pain in Forearm / Wrist
_____ Pain in Hands / Fingers
_____ Pins & Needles in Arms / Fingers
_____ Numbness in Arms / Fingers
_____ Hands Cold
_____ Joints in Fingers Swollen / Sore
_____ Loss of Grip Strength

MID BACK:
_____ Mid Back Pain / Stiffness
_____ Pain Between Shoulder Blades

CHEST:
_____ Chest Pain
_____ Shortness of Breath
_____ Pain Around Ribs
_____ Irregular Heartbeat / Palpitations

Height: _____ ft ._____in **Weight**_____

LOW BACK:
_____ Low Back Pain / Stiffness
_____ Tailbone Pain

HIPS, LEGS & FEET
_____ Pain in Buttocks (R / L)
_____ Pain in Hip Joint (R / L)
_____ Pain Down Leg (R / L / Both)
_____ Knee Pain
_____ Cramps in Legs / Feet (R / L)
_____ Pins & Needles in Feet / Toes
_____ Pins & Needles in Legs (R / L)
_____ Numbness of Leg (R / L)
_____ Feet Feel Cold
_____ Swollen Ankles / Feet (R / L)
_____Weak, Painful Feet (R / L)
_____ Numbness of Toes

ABDOMEN:
_____ Pain in Abdomen
_____ Gas / Bloating
_____ Constipation, Diarrhea

MENTAL:
_____ Loss of Memory / Concentration
_____ Disoriented
_____ Light-Headed / Dizzy
_____ Nausea / Vomiting
_____ Insomnia / Sleep Disturbance
_____ Nightmares
_____ Irritability
_____ Depression
_____ Anxiety
_____ Fatigue
_____ Uncoordinated Arms / Legs
_____ Falling to One Side
_____ Numbness / One Side of Body
_____ Speech Problems
_____ Fear of Driving
_____ Personality Changes

RECENT CHANGE IN:
_____ Bladder / Urine Function
_____ Bowel Function
_____ Menstrual Function
_____ Sexual Function
_____ Weight Gain / Loss
_____ Sleep Habits
_____ Emotional Strain
_____ Work Stress

When you are finished go back over the list and circle the three (3) worst symptoms.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various mode 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 named below and/or other licenses Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or 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 other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to 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 and for any future condition(s) for which I seek treatment.

To be completed by patient:

As: _____
Relationship or Authority of Patient's Representative

_____
Print Patient's Name

_____
Date Signed

_____
Signature of Patient

Print name(s) of doctor(s) treating this patient:

Dr. Kenneth Greenberg DC

_____

_____

Date_____

To be completed by doctor or staff
Name and address of clinic/office:

San Diego Chiropractic

8312 Lake Murray Blvd. Suite O

San Diego CA 92119

Witness to Patient's Signature:

Translated by:

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

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We accept payment in the form of cash, check or credit card.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or considered necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Interest will be accrued at a rate of 18%. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**