CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

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

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

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

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) _____

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) _____

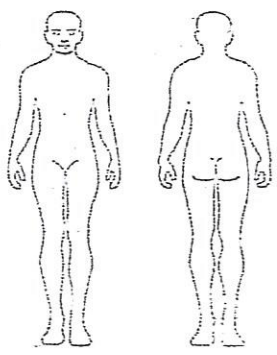
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



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		

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____)_____

[Practice Letterhead]

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize American Family Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____/____/____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying American Family Chiropractic in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by American Family Chiropractic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

AMERICAN FAMILY CHIROPRACTIC * 513-398-6300 * 513-398-6363

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize my health care provider_____ to use or disclose my health information during the term of this Authorization to American Family Chiropractic.

Information to be disclosed:

I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ☐ Only the following records or types of health information:

  _____.

_____ _____ _____

Signature Date Signature of Witness

_____ _____ _____

Name of Guardian/ Legal Relationship Date

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Medical Payment Information for Billing

Please provide your injury information below.

NAME OF MCO: _____

ADJUSTER NAME: _____

ADJUSTER PHONE NUMBER: _____

ADJUSTER EMAIL: _____

CLAIM NUMBER: _____

YOUR NAME: _____

Date of the accident: _____ Have you missed any work? Yes No

Did you go to any other doctors and list them? Yes No

_____

_____

_____

_____

_____

AUTOMOTIVE ACCIDENT HISTORY

NAME: _____ DATE: _____

DATE OF ACCIDENT: _____ TIME: _____ AM PM

CITY OF
ACCIDENT:_____STREET:_____

ROAD CONDITIONS AT THE TIME OF ACCIDENT: **WET, DRY, ICY, OTHER**
WERE THE POLICE CALLED? **YES---NO** IS THERE A POLICE REPORT? **YES---NO**
WERE YOU TAKEN TO THE HOSPITAL? **YES------NO**
NAME OF HOSPITAL: _____
HOW DID YOU GET TO THE HOSPITAL? _____
DID THEY PERFORM X-RAYS? _____
WERE YOUR INJURIES TREATED? **YES---NO** WHAT DID THEY DIAGNOSE YOUR INJURIES AS?_____
HOW LONG WERE YOU AT THE HOSPITAL?_____
ANY BLEEDING FROM THIS ACCIDENT?_____
ANY BRUISING FROM THE ACCIDENT?_____
WHERE WERE YOU SITTING IN THE VEHICLE?_____
WHERE WAS THE IMPACT ON YOUR VEHICLE?_____
WAS YOUR VISION COMPROMISED?_____
WERE YOU AWARE OF THE UPCOMING IMPACT OR CAUGHT OFF GUARD?_____
DID YOU LOSE CONSCIOUSNESS? YES----NO IF SO, FOR HOW LONG?_____
DID YOU EXPERIENCE A FLASH OF LIGHT OR EXPLOSION IN YOUR HEAD? **YES----NO**
DID YOU BECOME CONFUSED, DISORIENTED, LIGHT HEADED, DIZZY, NAUSEATED, BLURRED VISION, RINGING IN EARS? PLEASE CIRCLE ALL THAT PERTAIN.

DO YOU STILL HAVE THESE SYMPTOMS? YES---NO IF SO, WHICH ONES?_____

ARE YOU CURRENTLY SUFFERING FROM ONE OF THE FOLLOWING: **RESTLESSNESS, DIFFICULT CONCENTRATING, SLEEPLESSNESS, REDUCED TOLERENCE TO HEAT, IRRITABLE, DIFFICULTY WITH MEMORY, FORGETFULLNESS, REDUCED TOLERENCE TO ALCOHOL?**

HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD?
APPROXIMATELY _____ INCHES ABOVE AND BELOW.

WERE YOU WEARING A SEATBELT? **YES ------ NO WAS IT A LAP, SHOULD OR BOTH?**

LIST MAKE, MODEL, YEAR OF THE VEHICLE YOU WERE IN?_____

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? **YES------NO**
IF YES, WAS THE DRIVERS FOOT ON THE BRAKE? **YES----NO**
IF NO, ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN _____ MPH

HOW WAS YOUR VEHICLE MOVING AT THE TIME OF IMPACT?
SLOWING DOWN?__ GAINING SPEED?__ TRAVELING AT A STEADY RATE OF SPEED?__

WHAT PART OF THE AUTOMOBLE DID YOUR BODY PARTS HIT?
HEAD HIT? _____ **CHEST HIT?**_____
RIGHT/LEFT SHOULDER?_____ **RIGHT/LEFT ARM** _____
RIGHT/LEFT HIP HIT? _____ **RIGHT/LEFT LEG?**_____
RIGHT/LEFT KNEE?_____

DID YOU RECEIVE ANY INJURY OR BRUISE FROM THE SEATBELT? PLEASE DESCRIBE._____
_____
_____

WHAT IS THE ESTIMATED COST OF DAMAGE TO THE VEHICLE YOU WERE IN? $_____

WHICH OF THE FOLLOWING CAR PARTS BROKE DURING THE ACCIDENT?

____ **WINDSHIELD**
____ **FRONT SEAT**
____ **BACK RIGHT**
____ **LEFT SIDE**
____ **WINDOW**
____ **STEERING WHEEL**
____ **OTHER**

WAS THE TRUNK OF YOUR BODY POINTED STRAIGHT FORWARD AT THE TIME OF IMPACT?

IF NO, HOW WAS IT TURNED? _____

WAS YOUR HEAD POINTED STRAIGHT FORWARD? **YES---NO**
IF NO, WHAT DIRECTION WAS IT TURNED AND HOW MUCH?_____

HOW WAS THE OTHER VEHICLE MOVING AT THE TIME OF IMPACT?
APPROXIMATE SPEED OF OTHER DRIVER? _____ MAKE & MODEL OF OTHER VEHICLE. _____

SLOWING DOWN? __
GAINGING SPEED?__
TRAVELING AT A STEADY SPEED?___

PLEASE DESCRIBE, TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT?

_____
_____
_____
_____
_____
_____
_____
_____

Automobile Medical Payment Assignment

I, _____ was involved in an auto accident on _____in which I have been injured. **This accident was/wasn't my fault.**

I now assign without any right to later revoke, any/all proceeds from my settlement equal to the fees incurred by me to American Family Chiropractic. This assignment does not assign my settlement in full, only the fees incurred by me for services rendered by the physician at American Family Chiropractic. Any obligator will be bound at the moment proceeds from my settlement exist. Separate and apart from my attorney or myself in pursuit of my settlement, I will submit a claim for my medical payment coverage to cover fees for services rendered to me from American Family Chiropractic.

I understand this agreement and all documents that I have signed in connection with my automobile accident and my medical payment coverage. I understand that any fees not paid out of my settlement will be my responsibility. I understand that it is my responsibility during and after my treatment to remain aware of my cumulative account balance for all services rendered by American Family Chiropractic. I understand that this is an express contract to ensure payment for services rendered by American Family Chiropractic. I agree to pay my balance in full regardless of whether any other person or entity attempts to or fails to fully reimburse me for it.

NOTICE: I direct any insurance company, my attorney, or other person who holds any proceeds from my settlement, to apply those proceeds to my total balance. Any obligator must include American Family Chiropractic as a joint payee on all settlement drafts issued to me. Total proceeds held by an attorney for my settlement shall mean proceeds after deduction of attorney fees, however, medical payment proceeds received or held by the attorney shall NOT be subject to prior deduction of any attorney fees.

This is assignment is governed by Ohio Law. Jurisdiction shall be in Ohio and venue shall lie in any Ohio county permitted by law.

I agree to ensure that American Family Chiropractic is paid in full and that any use by me of these assigned proceeds is taking and converting money that is the property of American Family Chiropractic.

_____ _____

Patient Signature **Date signed**