FAMILY CHIROPRACTIC

Registration and History

1 PATIENT INFORMATION

Date_____

Social Security #_____

Patient Name_____
(Last Name)

_____
(First Name) (Middle Initial)

E-mail_____

Address_____

City_____

State_____ ZIP_____

Sex ☐ M ☐ F Age_____

Birth date_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____Yrs

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone (___)_____

Spouse's Name_____

Birth date_____

SS#_____

Spouse's Employer_____

Who may we thank for referring you? _____

_____

2 INSURANCE INFORMATION

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co._____

Patient ID # _____Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birth date_____ SS# _____

Relationship to Patient_____

Insurance Co._____

Patient ID # _____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))

Wang Family Chiropractic 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 clinic 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 FAMILY INFORMATION

Children's Name(s)	Sex	Date(s) of birth
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____

5 PATIENT CONDITION

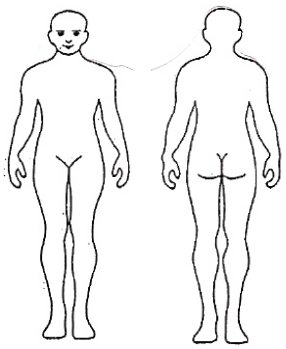
Reason for Visit_____

If we can help you, do you want our help? ☐ Yes ☐ No ☐ Unsure

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	Chicken Pox	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Emphysema	□ Yes □ No	Migraine Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Miscarriage	□ Yes □ No	Stroke	□ Yes □ No
Anorexia	□ Yes □ No	Fractures	□ Yes □ No	Mononucleosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Appendicitis	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Thyroid Problem	□ Yes □ No
Arthritis	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Tonsillitis	□ Yes □ No
Asthma	□ Yes □ No	Gonorrhea	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Gout	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors, Growths	□ Yes □ No
Breast Lumps	□ Yes □ No	Heart Disease	□ Yes □ No	Parkinson's disease	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bronchitis	□ Yes □ No	Hepatitis	□ Yes □ No	Pinched Nerve	□ Yes □ No	Ulcers	□ Yes □ No
Bulimia	□ Yes □ No	Hernia	□ Yes □ No	Pneumonia	□ Yes □ No	Vaginal infections	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Polio	□ Yes □ No	Venereal Disease	□ Yes □ No
Cataracts	□ Yes □ No	Herpes	□ Yes □ No	Prostate Problem	□ Yes □ No	Whooping Cough	□ Yes □ No
Chemical Dependency	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No	Other:_____	

Are you pregnant? □ Yes □ No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

7 LIFESTYLE

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□ Smoking
□ Alcohol
□ Coffee/ Caffeine Drinks
□ High Stress Level

VALUES
Please list your interests in order of importance from 1 to 7 (1= most important)

____ Family _____ Financial ____ Social
____ Physical _____ Mental ____ Spiritual
_____ Work

8 MEDICATIONS

_____
_____
_____

Pharmacy Name:_____
Pharmacy Phone:(_____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/ SUPPLEMENTS

_____
_____
_____
_____
_____

FAMILY CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic only has one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above practice and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____/_____/_____

_____ _____
(Signature) (Date)

FAMILY CHIROPRACTIC

AGREEMENTS AND AUTHORIZATION

CONSENT TO HEALTH CARE SERVICES/RELEASE OF HEALTH CARE INFORMATION

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Wang Family Chiropractic. The Patient health care services will be provided by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals employed, under contract, or otherwise retained by Chiro One. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____initial

PAYMENT GUARANTEE

In consideration of the services provided by Wang Family Chiropractic, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Wang Family Chiropractic, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Wang Family Chiropractic. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered.

_____initial

MEDICARE

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. You authorize payment or authorized benefits to Wang Family Chiropractic on Patient's behalf.

_____initial

PLEASE CONTINUE AND SIGN CONSENT TO RELEASE OF INFORMATION

FAMILY CHIROPRACTIC

CONSENT TO RELEASE OF INFORMATION

You authorize Wang Family Chiropractic to release to employer groups, government agencies, insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnoses and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Wang Family Chiropractic for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Wang Family Chiropractic or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, request Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Wang Family Chiropractic is required, under Illinois law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative.

_____initial

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Wang Family Chiropractic for safekeeping under its sole care and custody

No revisions or changes to this form, by you, will be accepted by the Chiro One.

_____

Signature of Patient or Responsible Party (parent, guardian or other representative) **Date**

_____

Signature of Policyholder **Relationship** **Date**

_____

Signature of Witness to signing of consent form **Date**

FAMILY CHIROPRACTIC

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby state that by signing this Consent I acknowledge and agree as follows:
(Print Name)

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at www.wangfamilychiropractic.com. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)	Date Signed	Signature of Individual
Signature of Legal Representative	Date Signed	Relationship
Witness (Office Personal)	Date Signed	