

PATIENT REGISTRATION

PATIENT

THIS SECTION REFERS TO PATIENT ONLY

Patient: _____ Date of birth _____ Today's Date _____ Male Female
LAST FIRST MIDDLE

Address: _____ Social Security #: _____

City, State, Zip: _____ EMAIL Address _____

Home Phone # (____) _____ Who Referred You? _____ Relationship _____

Work phone # (____) _____ Ext _____ Cell phone # (____) _____

Marital Status: M S W D # of Children (boys) _____ ages _____ (girls) _____ ages _____

PCP _____ PHONE#(____) _____ ADDRESS _____

Employer: _____ Spouse's Occupation: _____

Employer's Address: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

Spouse's Work Phone #: (____) _____

If you are a winter visitor please give your local address and phone #: _____

In Case of emergency, notify _____ Relationship _____ Phone # (____) _____

BILLING

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Institute / Name of Responsible Party: _____ Date of Birth _____ Claim / SS#: _____

Address: _____ Relationship to Patient: _____

City, State, Zip: _____ Employer: _____

Phone: (____) _____ ext: _____ Address: _____

2nd Phone: (____) _____ ext: _____ City, State, Zip _____

As the party responsible, I agree that all charges that are not directly paid by my insurance will be my responsibility.

Responsible Party Signature: _____

INSURANCE

PLEASE SUPPLY INFORMATION FOR BOTH INSURANCE CARRIERS IF APPLICABLE

Primary Carrier Name: _____ Secondary Carrier Name: _____

Address: _____ Address: _____

Phone # (____) _____ Policy # _____ Phone #: (____) _____ Policy # _____

Insured: _____ DOB _____ Insured: _____ DOB _____

SS# _____ Patient: Self Child Spouse Other SS# _____ Patient: Self Child Spouse Other

Group #: _____ Copay: _____ Group #: _____ Copay: _____

I hereby authorize payment of medical benefits to CWC, PLLC for services rendered. I hereby authorize CWC, PLLC to release any medical information necessary to complete and process my insurance claims.

Information taken by: _____

Patient or Guardian's Signature: _____ Date: _____

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic, nutritional and other procedures, including various modes of physiotherapy, massage therapy and diagnostic tests, on me (or on the patient named below, for whom I am legally responsible) by the licensed physician (s) and/or other healthcare providers who now or in the future work at the clinic or office listed above or any other office or clinic. I have had an opportunity to discuss with the physician (s) and/or other healthcare provider (s) and/or with other office or clinic personnel the nature and purpose of treatments and other procedures. I understand that results are not guaranteed. I understand and am informed that, in the practice of chiropractic and other applicable methods of treatment, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the physician (s) and/or other healthcare provider (s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the physician (s) and/or other healthcare provider (s) to exercise judgment during the course of the procedure which the physician (s) and/or other healthcare provider (s) feels at the time, based upon the facts then known to him or her, is in my best interest. 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.

Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Chiropractic Wellness Center, PLLC 'Notice of Privacy Practices'. This Notice describes how Chiropractic Wellness Center, PLLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initials

RESPONSIBILITY FOR PATIENT

Understanding that a reasonable effort will be made to collect the sums due from the insurance company or companies contractually obligated, Chiropractic Wellness Center, PLLC will refrain from collecting amounts owed. I understand that whatever amounts not collected from the insurance company or companies, whether it be all or part of what is due, I personally owe and agree to pay in full.

I understand and agree that for all unpaid balances over 30 days, I will be assessed a monthly finance charge of 1.5%. In addition to the above, I hereby acknowledge that if my account is turned over for collection, that I will be assessed any and all collection costs incurred by this clinic.

I understand that a fee of **\$45** will be charged to my account for appointments missed or cancelled **WITHOUT 24 HOURS ADVANCED NOTICE.**

Initials

METHOD OF PAYMENT

Cash_____ Insurance_____ Auto Accident/3rd party_____ Workers Compensation_____

PATIENT'S NAME _____ **DATE** ____/____/____

PATIENT'S Signature _____ **DATE** ____/____/____

PARENT/GUARDIAN SIGNATURE (if required) _____

PATIENT INTRODUCTION FORM

NAME _____ AGE _____ D.O.B ____/____/____ TODAY'S DATE ____/____/____

SPORTS / ACTIVITIES YOU PARTICIPATE IN _____

SPOUSE/ CHILDREN/ FAMILY ACTIVITIES _____

HAVE YOU HAD PREVIOUS CARE FOR YOUR CURRENT CONDITION? Y / N WHERE _____

WOMEN—ANY POSSIBILITY YOU COULD BE PREGNANT? Y / N 1ST DAY OF LAST CYCLE ____/____/____

REASONS FOR CONSULTING THIS OFFICE (check all that apply) :

- PAIN
- SPORTS INJURY
- AUTO ACCIDENT
- PERSONAL INJURY
- WORK RELATED INJURY
- INTERESTED IN NUTRITION
- TO OBTAIN OPTIMAL HEALTH & PERFORMANCE
- OTHER _____

WHICH OF THE FOLLOWING HAVE YOU BEEN EXPERIENCING DIFFICULTY, OR BEEN DIAGNOSED WITH (PLEASE CHECK ALL THAT APPLY)?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> FOOT/ TOE PAIN | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> TINGLING IN LEGS/ FEET | <input type="checkbox"/> STOMACH PROBLEMS | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> COLD FEET | <input type="checkbox"/> DIFFICULTY | <input type="checkbox"/> HEART PROBLEMS |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> SWALLOWING | <input type="checkbox"/> HEART ATTACK/
DISEASE |
| <input type="checkbox"/> BACK STIFFNESS | <input type="checkbox"/> PAINFUL JOINTS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> DISC PROBLEMS | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> SHOULDER PAIN | <input type="checkbox"/> NIGHT PAIN | <input type="checkbox"/> ABNORMAL STOOLS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> ARM PAIN | <input type="checkbox"/> EXCESSIVE FATIGUE | <input type="checkbox"/> PAINFUL BOWEL
MOVEMENTS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ELBOW PAIN | <input type="checkbox"/> LOW EXERCISE LEVEL | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> WRIST PAIN | <input type="checkbox"/> POOR DIET | <input type="checkbox"/> BLADDER PROBLEMS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> HAND/ FINGER PAIN | <input type="checkbox"/> FAINTING | <input type="checkbox"/> PROSTATE PROBLEMS | <input type="checkbox"/> DIZZINESS/VERTIGO |
| <input type="checkbox"/> TINGLING IN ARM/HAND | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> MENSTRUAL PROBLEMS | <input type="checkbox"/> BALANCE PROBLEMS |
| <input type="checkbox"/> COLD HANDS | <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> GALL BLADDER
PROBLEMS | <input type="checkbox"/> COORDINATION
PROBLEMS |
| <input type="checkbox"/> HIP PAIN | <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> VISION PROBLEMS |
| <input type="checkbox"/> LEG PAIN | <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> KNEE PAIN | <input type="checkbox"/> ALLERGIES | | |
| <input type="checkbox"/> ANKLE PAIN | <input type="checkbox"/> ASTHMA | | |

ANY CONDITION/CONCERN NOT LISTED ABOVE _____

DO YOU SMOKE: Y / N YEARS _____ PACKS PER DAY _____

DO YOU DRINK ALCOHOL Y / N YEARS _____ DRINKS PER WEEK _____

RATE YOUR TYPICAL STRESS LEVEL (OVERALL): 1 2 3 4 5 6 7 8 9 10+
MILD MODERATE SEVERE DISABLING

HOW MANY HOURS DO YOU WORK PER WEEK: _____

HOW MANY HOURS DO YOU SIT IN YOUR CHAIR PER DAY _____

DESCRIBE WHAT YOU DO AT YOUR JOB _____

HAVE ANY OF YOUR BLOOD RELATIVES BEEN AFFECTED BY THE FOLLOWING CONDITIONS: (Indicate which family member. For example: Father, mother, grandmother, grandfather, aunt, uncle, etc.)

- | | | |
|---|--|--|
| <input type="checkbox"/> RHEUMATOID ARTHRITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> THYROID DISORDERS | <input type="checkbox"/> CANCER | <input type="checkbox"/> LIVER DISEASE |

OTHER _____

