NIELSON CHIROPRACTIC CENTER, INC.

Patient Registration and History

Patient Information

Date_____

Social Security Number_____

Name_____

Address_____

_____

Sex ☐M ☐F Age_____ Birthdate_____

☐Single ☐Married ☐Widowed ☐Divorced

Occupation_____

Employer_____ Phone_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

Contact Information

Home Phone_____

Work Phone_____ Ext_____

Cell Phone_____

Email Address_____

In case of emergency, contact

Name_____ Relationship_____

Home Phone_____

Work Phone_____

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_____

Relationship to patient_____

Insurance Co._____ Group#_____

Assignment and Release

I the undersigned, certify that I (or my dependant) have insurance coverage with the above mentioned carrier and assign directly to Nielson Chiropractic Center, Inc. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Dr. Nielson and/or his staff to examine and/or treat me (or my dependant).

_____

Responsible Party Signature

_____

Relationship Date

Accident Information

Is condition due to an accident? ☐yes ☐no Date_____

Type of accident ☐auto ☐work ☐home ☐other

Accident reported to ☐auto ins. ☐employer ☐worker comp. ☐other

Attorney (if applicable)_____

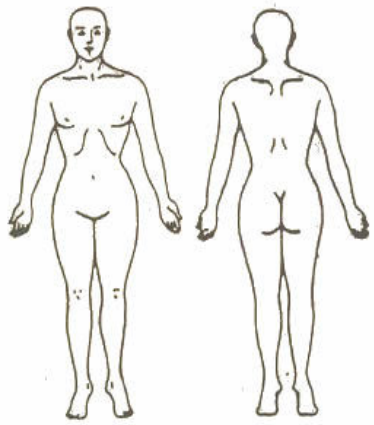
Patient Condition

Reason for visit _____

When did your symptoms begin?_____

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 (most 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?

Overall Health – Please indicate your feelings about your overall health by circling the corresponding number:

1 2 3 4 5 6 7 8 9 10

Health History

Have you ever seen a Chiropractor before? ☐yes ☐no

What treatment have you already received for your condition? ☐medications ☐surgery ☐physical therapy ☐chiropractic

Name of Physician_____ May we contact your physician to update her/him on your condition? ☐yes ☐no

Date of last: physical exam_____ spinal x-ray_____ blood test _____ chest x-ray_____

Urine test_____ dental x-ray_____ MRI, CT scan, bone scan_____

Do you wear: ☐heel lifts ☐shoe lifts ☐arch supports ☐orthotics, describe_____

Do you sleep on your: ☐back ☐side ☐stomach Age of mattress_____ Is your bed comfortable? ☐yes ☐no

What kind of pillow do you use? ☐thick ☐thin ☐none ☐support

Symptoms –check (x) conditions you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bones

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose Veins

Eye/Ear/Nose/Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changing in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Men Only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of Last:

Menstrual period_____

Pap Smear_____

Mammogram_____

Are you pregnant? ☐ yes ☐ no

Conditions—Check (x) conditions you currently have or have had in the past.

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications—List any medications you are currently taking **and the reason.**

_____

_____

_____

_____

Vitamins—List all vitamins and supplements you are taking.

_____

_____

_____

Medical History—List any hospitalizations and/or major illnesses/injuries:

	Year

Pregnancies

Year of birth	Sex of Child	Complications if any:

Allergies

Health Habits—Check the substances used and how much:

☐Caffeine_____

☐Tobacco_____

☐Drugs_____

☐Other_____

Occupational—Does your job expose you to:

☐Stress

☐Hazardous Substances

☐Heavy Lifting

☐Other_____

Family History

	Mother	Father	Sibling
Diabetes	☐	☐	☐
Heart	☐	☐	☐
Kidney	☐	☐	☐
Cancer	☐	☐	☐
Back	☐	☐	☐
Other	☐	☐	☐

Office Financial Policy

Cash

1. All patients are on a cash basis until their insurance covering and deductible is verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any plan or arrangement will be discussed during your report of findings

Insurance

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on wellness care, we will continue to file your insurance, but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any explanation of benefits from your insurance, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check—it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any service not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately—regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the Front Desk Staff.
9. If your account becomes delinquent to the point of being turned over to an Independent collection agency, any collection charges incurred will be added to your balance and will be your responsibility.

I have read and understand the Office Financial Policy and agree to abide by these terms.

Signature_____

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you t his disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health care information within our practice for quality control or other operational procedures.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment, or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Disclosure of Use

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, they are binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also agree to allow this clinic to contact me by mail, telephone, or any other method for appointment reminders, financial statements, insurance concerns, office promotions, marketing information, fund raising requests or any other information that my be of interest to me. I also acknowledge that I have received a copy of this notice, if I desire.

Print Name	Date
Signature	Witness Signature