Chiropractic Registration and History

Patient Information

Patient Name: _____

DOB: _____ Gender: Male Female

Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ Secondary:_____

Social Security Number:_____

Marital status:

Married Widowed Divorced Single

Occupation: _____

Employer or school: _____

Emergency Contact:

Name:_____

Number: _____Relationship: _____

Whom may we thank for referring you?

_____

_____

I certify that all the above information is correct:

Sign:_____ Date:_____

Insurance Information

PRIMARY

Insurance Company:_____

Subscriber name: _____

ID #: _____ Group#: _____

SECONDARY

Insurance Company: _____

Subscriber Name: _____

ID#: _____ Group#:_____

Assignment and release:

I certify that I, and/or my dependent(s) have ins. coverage with _____ and assign directly to Drs Young and Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by my 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 these services and determining insurance benefits payable for related services.

Sign:_____ Date:_____

Patient Condition

Reason for visit: _____
_____

Is this condition due to an accident? Yes No Date:_____ Type: Work Auto Other

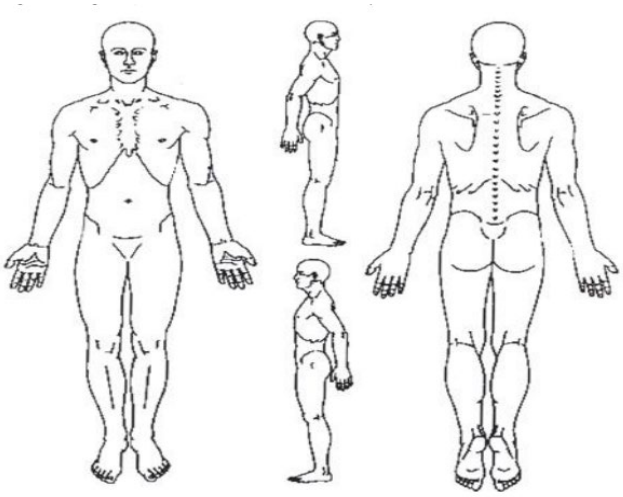
To whom have you made a report of your accident: Employer Worker Comp. Other

Attorney name: _____ Law Firm: _____

When did symptoms start: _____ Has it become progressively worse? Yes No

Mark the picture where you have pain.

XXXXXXX ********* /////////// >>>>>>>>> ~~~~~~~~
Aching Numbness Tingling Stabbing Pins & needles



Rate the severity of your pain on a scale of 1-10: _____
(1 being the least, 10 being the worst)

Type of pain: Sharp Burning Throbbing Numbness

Aching Shooting Burning Tingling

Cramps Stiffness Swelling

Other: _____

How often do you have this pain? _____

Is the pain constant or come and go? _____

Does the pain interfere with: Work Sleep Daily Routine Recreation

Activities that are painful to preform? Sitting Standing Walking Bending Laying Down

By signing below I certify that all information I have provided is correct. I understand that providing incorrect information could be detrimental to my health.

Sign: _____ Date:_____

Print: _____

Health History

Patient Name: _____ DOB: _____

What treatment have you received for your condition? Medication Surgery Physical Therapy
Chiropractic None Other:_____

Name of doctor(s) who have treated you for this 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: _____

Please circle yes or no to indicate if you have any of the following:

AIDS/HIV	yes	no	Liver Disease	yes	no
Alcoholism	yes	no	Measles	yes	no
Allergy Shots	yes	no	Migriane Headaches	yes	no
Anemia	yes	no	Miscarriage	yes	no
Anorexia	yes	no	Mononucleosis	yes	no
Appendicitis	yes	no	Multiple Sclerosis	yes	no
Arthritis	yes	no	Mumps	yes	no
Asthma	yes	no	Osteoporosis	yes	no
Bleeding Disorder	yes	no	Pacemaker	yes	no
Breast Lump	yes	no	Parkinson's Disease	yes	no
Bronchitis	yes	no	Pinched Nerve	yes	no
Bullimia	yes	no	Pneumonia	yes	no
Cancer	yes	no	Polio	yes	no
Cataracts	yes	no	Prostate problem	yes	no
Chemical Dependency	yes	no	Prosthesis	yes	no
Chicken Pox	yes	no	Psychiatric care	yes	no
Diabetes	yes	no	Rheumatoid Arthritis	yes	no
Emphysema	yes	no	Rheumatic Fever	yes	no
Epilepsy	yes	no	Scarlet Fever	yes	no
Fractures	yes	no	STD	yes	no
Glaucoma	yes	no	Stroke	yes	no
Goiter	yes	no	Suicide Attempt	yes	no
Gonorrhea	yes	no	Thyroid Problem	yes	no
Gout	yes	no	Tonsilitis	yes	no
Heart Disease	yes	no	TB	yes	no
Hepatitis	yes	no	Tumors/Growths	yes	no
Hernia	yes	no	Typhoid Fever	yes	no
Herniated Disk	yes	no	Vaginal Infections	yes	no
Herpes	yes	no	Whooping Cough	yes	no
High Blood Pressure	yes	no	Other: _____		
High Cholesterol	yes	no	_____		
Kidney Disease	yes	no			

Health History Continued

Patient Name:_____ DOB: _____

Exercize	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day: _____
Moderate	Standing	alcohol	Drinks/Week:_____
Daily	Light Labor	coffee/caffiene	Cups/Day:_____
Heavy	Heavy Labor	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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing below I certify that all information I have provided is correct. I understand that providing incorrect information could be detrimental to my health.

Sign: _____ Date:_____

Print: _____

Medical Records Release: HIPAA Authorization to Use or Disclose Health Information

Patient Name: _____ DOB:_____

Address:_____ Telephone: _____

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual(s) or organization(s) are authorized to make disclosure: _____
_____

The type of information to be used or disclosed is as follows (check the appropriate boxes)

- Entire medical record
- Lab results
- Xray and imaging reports
- Consultation reports
- Other (Please describe): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), of human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used or disclosed to the following individuals or organization(s):

Pueblo Chiropractic Center
1211 Paseo Del Norte
Pueblo, CO 81008
P: 719-542-1399
F: 719-583-2024

This information for which I authorize disclosure will be used for the following purpose:
CONTINUED TREATMENT

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal Representitive:_____ Date:_____

Printed Name:_____ Relationship to patient: _____

HIPAA Act ACS X12

** Rule 5010 for Health Care Providers effective 01/01/12: The Dept. of Health & Human Services rule 45 CFR Part 162 of the Health Insurance Reform; Hippa Act, ACS X12 standards, requires all health care providers to report race ethnicity and language spoken. **

Race: Asian Black Caucasian Other Declined

Ethnicity: Hispanic Non- Hispanic Declined Language Spoken: _____

Privacy Policy

Privacy Practice Notice:

I have read the notice of Privacy Practices and do understand my rights. I understand that my doctor and their staff shall preserve the integrity and confidentiality of protected health information.

Copy requested: _____ No Copy Requested: _____

Consent to Treat

I give consent to be treated myself or for the individual to whom I am responsible for.

Signature of patient or guardian: _____ Date: _____

Pueblo Chiropractic Center

Welcome to our practice!

Please be advised we will submit all charges to your insurance, however it is your responcibility to provide our office with updated insurance information. This includes auto insurances or personal injury (if applicable).

Financial Policy

*You are required to pay, in full, for each visit at the time of service. Your co-pay is required to be payed each visit. If you have a deductible amount remaining you will be balance billed the amount due for the services rendered after the co-pay has been applied.
*If your insurance eligibility requires a co-insurance amount to be collected and you have not met your deductible you will be charged the full contracted amount per your insurance.
*Co-Insurance balances are due within 30 days of EOB receipt. Please monitor your insurance explanation of benefits for clarification.
*Any patient portion amounts that are revealed via Explanation of Benefits will be sent sent to you via a balance statement and you will have 30 days to pay balance before notification of non-payment is reported to your insurance.
*All non/payments are monitored by insurance and could result in termination of coverage.
*You are required to inform Pueblo Chiropractic Center of any change in name or address
* If you are being treated for a work related or auto related injury, it is your responsibility to provide our office with any and all information necessary to receive payment or it could be your responsibility to pay.
*If you fail to pay on your account when due or fail to comply with any other term in this financial policy the balance on the account will be considered in default.
* Should Pueblo Chiropractic Center prevail in a lawsuit to collect in this debt , Pueblo Chiropractic Center will include all court costs, collection agency costs, and attorney's fees in an amount that the court finds reasonable.

I agree to the above and agree to be personally responsible for full payment of my account

Signature:_____ Date:_____

Print:_____