

# Chiropractic Registration and History

## Patient Information Insurance Information

Patient Name: **PRIMARY**

DOB: Gender: Male Female Insurance Company:

Address: Subscriber name:

City: State: Zip:

ID #:

Group#:

Phone Number: **SECONDARY**

Social Security Number: Insurance Company:

Marital status: Subscriber Name:

Married Widowed Divorced Single ID#: Group#:

Occupation: Employer or school: Emergency Contact:

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| **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.**Assignment and release VA/TriWest:**I (Veteran) hereby assign all medical benefits to provider. |

Name: Number: Relationship:

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| Whom may we thank for referring you? |
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| 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. |

I certify that all the above information is correct:

Sign: Date:

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| Sign: Date:  |
| PUEBLO CHIROPRACTIC CENTER |

# Patient Condition

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| Reason for visit:  |
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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

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| Mark the picture where you have pain. |
| XXXXXXX | \*\*\*\*\*\*\*\*\* | /////////// | >>>>>>>>> | ~~~~~~~~ |
| Aching | Numbness | Tingling | Stabbing | Pins & needles |

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

Other:

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| --- | --- | --- | --- | --- |
| Type of pain: | Sharp | Burning | Throbbing | Numbness |
|  | Aching | Shooting | Burning | Tingling |
|  | Cramps | Stiffness | Swelling |  |

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 perform? Sitting Standing Walking Bending Laying Down

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| 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:

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| **Health History** |
| Patient Name: DOB:  |

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| 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:  |

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| 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

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| --- | --- |
| yes | no |
| yes | no |
| yes | no |
| yes | no |
| yes | no |
| yes | no |
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| --- | --- | --- |
| Liver Disease | yes | no |
| Measles | yes | no |
| Migraine Headaches | yes | no |
| Miscarriage | yes | no |
| Mononucleosis | yes | no |
| Multiple Sclerosis | yes | no |
| Mumps | yes | no |
| Osteoporosis | yes | no |
| Pacemaker | yes | no |
| Parkinson's Disease | yes | no |
| Pinched Nerve | yes | no |
| Pneumonia | yes | no |
| Polio | yes | no |
| Prostate problem | yes | no |
| Prosthesis | yes | no |
| Psychiatric care | yes | no |
| Rheumatoid Arthritis | yes | no |
| Rheumatic Fever | yes | no |
| Scarlet Fever | yes | no |
| STD | yes | no |
| Stroke | yes | no |
| Suicide Attempt | yes | no |
| Thyroid Problem | yes | no |
| Tonsilitis | yes | no |
| TB | yes | no |
| Tumors/Growths | yes | no |
| Typhoid Fever | yes | no |
| Vaginal Infections | yes | no |
| Whooping Cough | yes | no |
| Other:  |
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Alcoholism Allergy Shots Anemia Anorexia Appendicitis Arthritis Asthma

Bleeding Disorder Breast Lump Bronchitis Bulimia

Cancer Cataracts

Chemical Dependency Chicken Pox

Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout

Heart Disease Hepatitis Hernia Herniated Disk Herpes

High Blood Pressure High Cholesterol Kidney Disease

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| **Health History Continued** |
| Patient Name: DOB:  |

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| **Exercise** |
| None |
| Moderate |
| Daily |
| Heavy |

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| **Work Activity** |
| Sitting |
| Standing |
| Light Labor |
| Heavy Labor |

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| **Habits** |
| Smoking |
| alcohol |
| coffee/caffeine |
| High stress level |

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| Packs/Day:  |
| Drinks/Week:  |
| Cups/Day:  |
| Reason:  |

Are you Pregnant? Yes No Due Date:

Injuries/surgeries you have had Description Date

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| Falls |
| Head injuries |
| Broken Bones |
| Dislocations |
| Surgeries |

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| Medications |
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| Allergies |
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| Vitamins/Herbs/Minerals |
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| 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:

PUEBLO CHIROPRACTIC CENTER

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| **Medical Records Release: HIPAA Authorization to Use or Disclose Health Information** |
| Patient Name: DOB:  |

Address: Telephone:

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| 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:  |
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| 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):  |

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| 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. |

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| 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 |

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

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| 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. |

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| 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 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 Representative: Date:

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| Printed Name: Relationship to patient:  |
| PUEBLO CHIROPRACTIC CENTER |

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| **Patient Information Sheet for Personal Injury** |
| Please fill out every line as each piece of information is extremely important for your case. |

Name: Social Security Number:

Date of Accident:

Emergency Room: Yes No If yes, what hospital? Ambulance Yes No

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| Physicians you have seen for this accident:  |
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Attorney:

Law Firm:

Phone:

## Work Comp Insurance

Your work comp insurance: Claim Number:

Adjuster: Phone Number:

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| **Your Auto Insurance** |
| Your Auto Insurance: Claim Number:  |

Was a claim filed with this insurance company? Yes No Medpay Benefit? Yes No Adjuster: Phone Number:

## At- Fault Information

At-Fault Insurance: Claim #:

Was a claim filed with this insurance company? Yes No Accepted Liability? Yes No Adjuster: Phone Number:

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| I certify that the above information is correct, and I understand that the above information is critical for the |
| billing of treatment rendered to me in this case. |

Signature: Date:

Print:

PUEBLO CHIROPRACTIC CENTER

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| **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 |

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| 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:  |

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| **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

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| **Pueblo Chiropractic Center** |
| Welcome to our practice! |
| Please be advised we will submit all charges to your insurance; however, it is your responsibility to provide |
| our office with updated insurance information. This includes auto insurances or personal injury (if applicable). |

**Financial Policy**

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| \*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:

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## Notice of Lien and Assignment of Benefits

Patient Name:

DOB: DOI:

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| This serves as notification that the above-named individual is being treated in our office in relationship to the |
| above mentioned accident and resultant injuries. |

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| Treatment in this office will be reasonable and necessary and will be directly related to the accident in question. |
| Utilization and charges for services provided will be consistent with historical auto related PPO utilization |
| guidelines, standard of care and fee schedules. |

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| Unfortunately, our office has experienced difficulties under the new system with at-fault payers and |
| the patient auto insurance company settling directly with injured parties and not paying our bills directly. This |
| has resulted in some injured parties failing to pay for their outstanding balances. Therefore, our office policy is to |
| only accept patients under an attorney lien or in which the patient's insurance company pays us directly. |
| However, if the patient terminates their attorney/client relationship, and is not represented at the time of |
| settlement, the patient will still be held responsible for services rendered at Pueblo Chiropractic Center. |

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| I do hereby authorize Pueblo Chiropractic Center, here after provider, to furnish you, my attorney with all reports |
| related any diagnostic testing and/or treatment related to the above incident. |

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| I give a lien regarding this incident to provider against the net proceeds of my settlement, judgement, or verdict, |
| exclusive of costs and attorney fees. |

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| I fully understand that I am directly and fully responsible to Pueblo Chiropractic Center for all bills submitted by the |
| provider for services rendered to me. I hereby **authorize, direct, and assign** proceeds payable from my insurance |
| company and/or a third-party insurance company to pay directly to Dr. Young/Dr. Graham such sums as may be due |
| and owed to them for services rendered to me by reason of this accident and by reason of any other bills due to |
| **adequately protect and fully compensate said doctor.**  |

I agree to notify the provider of any changes or addition of attorney(s) used by me in connection with this lien. Patient/ Guardian Signature: Date:

Attorney: Law Firm: Phone:

Attorney Signature: Date:

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