CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Cell Phone (_____) _____

Home Phone (_____) _____

E-mail _____

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Employer / School _____

Occupation _____

Employer / School Address _____

_____

Employer / School Phone (_____) _____

Spouse's Name _____

Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

2 PATIENT CONDITION

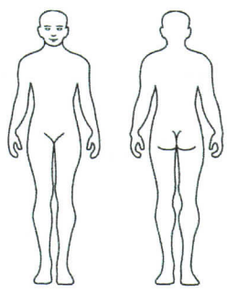
Reason for Visit: ❑ Spinal and Nervous System Check-up

❑ Other: _____

If there is a symptom, when did your symptom 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 of 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 ❑ Laying Down

3 INSURANCE INFORMATION

Insurance Co. _____

ID # _____

Is Patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

ASSIGNMENT AND RELEASE

I understand that I may receive a statement of services received and paid for to submit to my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

4 ACCIDENT INFORMATION

Is this consultation due to an accident? ❑ No ❑ Yes

If so, what was the date of Accident: _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

_____

Claim number: _____

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable) _____

Address _____

_____

Phone _____

5 HEALTH HISTORY

What health care have you already received for your condition?

❑ Chiropractic Care (Dr. _____ Date_____) ❑ Surgery (Dr. _____ Date_____)

❑ Medications (Dr. _____ Date_____) ❑ Physical Therapy (Dr. _____ Date_____)

❑ Other: _____ (Dr. _____ Date_____)

❑ None

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 Problems	❑ 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 Lump	❑ 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	Prostrate Problem	❑ Yes ❑ No	Whooping Cough	❑ Yes ❑ No
Chemical		High Cholesterol	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No	Other _____	
Dependancy	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	_____	

EXERCISE

❑ None
❑ Moderate
❑ Daily
❑ Heavy

WORK ACTIVITY

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

HABITS

❑ Smoking Packs/Day _____
❑ Alcohol Drinks/Week _____
❑ Coffee/Caffeine Drinks Cups/Day _____
❑ High Stress Level Reason _____

PREGNANCY

Are you currently pregnant? ❑ No ❑ Yes, and I am due _____

Number of past pregnancies _____

Children's Ages: Child #1 _____ Child #2 _____ Child #3 _____ Child #4 _____

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

6 MEDICATIONS

_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____

SUPPLEMENTS

_____
_____
_____
_____

Mariah's 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 has only 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 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 or condition other than vertebral subluxation. 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 a health care provider who specializes in that area.

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 subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Date

X-ray Release

This is to certify that the Drs. of Mariah's Family Chiropractic have my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____.

Signature Date

Consent to Care for Minor

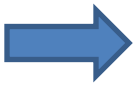
I authorize the Drs. of Mariah's Family Chiropractic and whomever they may designate as her assistant to administer care as she so deeds necessary to my son/daughter.

Signature Date

Insurance

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Mariah's Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mariah's Family Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

Signature Relationship to Patient Date



Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 1-319-246-1759. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

I understand this Cancellation/ Missed Appointment Policy

_____

Patient Signature

_____

Signature Date

_____

Printed Patient Name