CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Name: _____
First Name Initial Last Name

Address: _____

_____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Sex: ❑ M ❑ F Age: _____ Birth date:_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Social Security #: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone #: _____

Hours / Week Worked: _____

IN CASE OF AN EMERGENCY, CONTACT

Name:_____ Relation: _____

Phone #:_____

Is condition due to an accident? ❑ Yes ❑ No

❑ Auto (Complete Section 3 Below)

❑ Work / Home / Other *(Complete Section 4 on the next page)*

PRIMARY PHYSICIAN: _____

How did you hear about us? _____

2 INSURANCE INFORMATION

Health Insurance *(Primary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policyholder Date of Birth: _____

Policy #: _____ Group #:_____

Health Insurance *(Secondary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____ Group#:_____

Complete the following if injury is related to an auto accident.

Motor Vehicle Insurance *(Your PIP Info)*

Owner of vehicle in which you were injured:

_____

Ins Co.: _____ Phone:_____

Policy #: _____

Claim #: _____

Have you retained an attorney? ❑ Yes ❑ No

Name: _____ Phone:_____

Third Party Information *(Other vehicle that struck yours)*

Name: _____ Phone:_____

Ins Co.: _____ Phone:_____

Policy #: _____ Claim #:_____

3 Auto ACCIDENT INFORMATION *(IF APPLICABLE)*

Date of Injury:_____ Time:_____ State: ❑ DC ❑ MD ❑ VA ❑ PA ❑ Other _____

Describe in DETAIL how your injury occurred: _____

_____

_____

Were you the: ❑ Driver ❑ Passenger Were you sitting in the: ❑ Front Seat ❑ Back Seat

Were you struck from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side Were you wearing a seatbelt? ❑ Yes ❑ No

Did you know you were going to be hit? ❑ Yes ❑ No Did you brace for impact? ❑ Yes ❑ No

Approximate speed your vehicle was traveling _____mph *OR* were you stopped? ❑ Yes ❑ No

Approximate speed the other vehicle(s) were traveling _____mph

Make & Model of your vehicle:_____ Make & Model of other vehicle:_____

Were police notified? ❑ Yes ❑ No Did the police file a report? ❑ Yes * ❑ No

**** If yes, you must provide a copy of this report to this office within 5 business days of today's date.***

What was the approximate damage to vehicle: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Totaled

Amount of Damage: $_____ Was your vehicle towed from the scene? ❑ Yes ❑ No

Patient Name: _____

4 Work *(or Other)* Injury Information *(If Applicable)*

Date of Injury:_____ Time:_____ State: ❑ DC ❑ MD ❑ VA ❑ PA ❑ Other _____

Describe in DETAIL how your injury occurred: _____

_____

_____

_____

_____

_____

_____

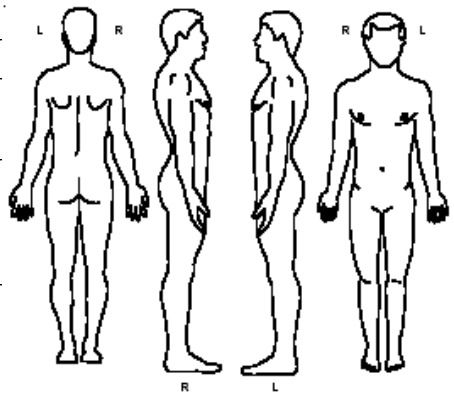
_____

_____

5 Current Complaints

What are your present complaints? *(Location of pain, etc.)*_____

_____



Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.

When did these symptoms first appear? _____

Do your symptoms interfere with: ❑ Sleep ❑ Daily routine ❑ Work ❑ Recreation

Are you working less hours / days as a result of your injuries? ❑ Yes ❑ No

If yes, please explain _____

Activities or movements that are painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

How would you rate your symptoms: ❑ Mild ❑ Moderate ❑ Severe

How would you rate your current symptoms (pain): ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Symptoms Worst Possible

Since the accident *(if applicable)*, are your symptoms: ❑ Improving ❑ Unchanged ❑ Worsening

6 Hospitalization / Examination History

Have you been to the hospital for *this* condition? ❑ Yes ❑ No If yes, name of hospital? _____

When did you go? _____ How did you get there? ❑ Ambulance ❑ Self ❑ Others

Were x-rays taken? ❑ Yes ❑ No If yes, what area(s)? _____

Were you prescribed any medication? ❑ Yes ❑ No If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? ❑ Yes ❑ No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date(s)	Test	Region / Body Part(s)	Date(s)
❑ Examination	_____	_____	❑ EMG / NCV	_____	_____
❑ MRI / CT	_____	_____	❑ _____	_____	_____

Patient Name: _____

7 HEALTH HISTORY / INJURIES / TREATMENTS

INJURIES YOU MAY HAVE HAD IN THE PAST Description Date (s)

Auto Accident (s) _____ _____

Work Injuries _____ _____

Broken Bones _____ _____

Other _____ _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: ***(place "✓" in boxes that apply)***

- ❑ Muscle disorder
- ❑ Nervous System Disorder
- ❑ Bone Disorder
- ❑ Rheumatoid Arthritis
- ❑ Allergies
- ❑ HIV
- ❑ Gallbladder
- ❑ Diabetes
- ❑ Depression
- ❑ Coughing Blood
- ❑ Stomach, Intestines (GI)
- ❑ Lungs, Asthma
- ❑ Broken Bones
- ❑ Eating Disorder
- ❑ Pace Maker
- ❑ Seizures/Convulsions`
- ❑ A Congenital Disease
- ❑ Excessive Bleeding
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Kidney, Bladder (GU)
- ❑ Circulatory Problems
- ❑ Osteoarthritis
- ❑ Epilepsy
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Strokes
- ❑ Cancer
- ❑ Ulcer
- ❑ Hernias
- ❑ Ears, eyes, nose, throat
- ❑ Tumors
- ❑ Heart Disease

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION: Date (s)

Spine Surgeries ❑ Discectomy ❑ Laminectomy ❑ Fusion ❑ Other:_____ _____

Other Surgeries _____ _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION: ***(place "✓" in boxes that apply)***

- ❑ Medication *(OTC / Prescription)*
- ❑ Injections
- ❑ Physical Therapy *(Dates:_____)*
- ❑ Massage
- ❑ Chiropractic
- ❑ Acupuncture
- ❑ Other: _____
- ❑ List ALL Meds: _____

Female patients: Start date of most recent menstrual cycle: _____ Are you currently pregnant? ❑ Yes ❑ No

8 YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

	Name	*Phone*
Primary / Family Doctor:	_____	_____
Orthopedic Doctor:	_____	_____
Pain Management:	_____	_____
Neurologist:	_____	_____
Chiropractor:	_____	_____

9 AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____

Patient Name: _____

Advanced Chiropractic of Grove City Consent to Services

PATIENT'S RIGHTS **Pt. Initials_____**

Advanced Chiropractic of Grove City (ACGC) respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD *(Under the age of 18)* **Pt. Initials_____**

I authorize Chiropractic &/or Rehab Therapy care as deemed necessary to my (relationship)_____.

FEMALE PATIENTS *(ONLY)* **Pt. Initials_____**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that ACGC has my permission to take x-rays. Beginning date of last menstrual period _____.

INITIAL EXAM & CONSULT VISIT (FIRST & SECOND Visit) **Pt. Initials_____**

This includes x rays and consult visit to receive results. An initial History & Physical will be sent to your Primary Care Doctor, unless otherwise requested.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment; if you take care) **Pt. Initials_____**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO CHIROPRACTIC &/OR PHYSICAL THERAPY SERVICES **Pt. Initials_____**

I hereby request and consent to comprehensive examinations (chiropractic &/or physical therapy orthopedic &/or neurological), chiropractic adjustments/treatments *(and other procedures including various modes of physiotherapy modalities)*, physical therapy intervention *(including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program)*, nutritional counseling/advice, and diagnostic x-rays by ACGC *(& it's staff)*, who now or in the future treat me in this office. I have had an opportunity to discuss with the ACGC Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of physical therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by ACGC and/or employed staff.

NO SHOW/CANCELLATION/LATE POLICY **Pt. Initials_____**

ACGC has the right to charge a fee of $25.00 for appointments not cancelled within 24 hours of scheduled time or not showing for scheduled appointment and payment will be due on next visit. If patients show up for appointments more than 15 minutes late we may re-schedule or full treatment will not be given.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED_____ **SIGNED**_____ **DATE**_____