CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this amount? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services renderd. 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.

_____
Responsible Party Signature

_____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date

_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____

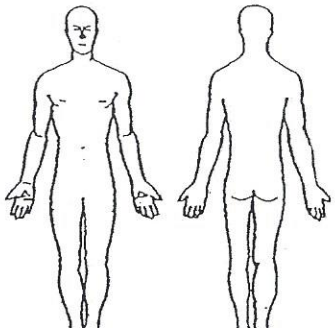
5 PATIENT CONDITION

Reason for visit _____

When did your symptoms 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 from 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? _____

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your 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 _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____	
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Measles	☐ Yes ☐ No				
Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ 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 _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

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

7 MEDICATIONS

_____

_____

Pharmacy Name _____

ALLERGIES

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

CHIROPRACTIC CARE & REHABILITATION

2811 Watson Blvd. Suite 3 | Warner Robins, GA 31088
Office (478) 971-4110 | Fax (478) 971-4072

NEIL SCHWARTZ, D.C.
Board Certified / Physiological Therapeutics

AUTHORIZATIONS AND RELEASES

CASE # _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. _____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests including not limited to radiographs and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance 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. I permit this office to endorse remittances for the conveyance of credit to my account. **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.**

Patient's Signature _____ Date ____ / ____ / ____ Witness _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date ____ / ____ / ____ Witness _____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to _____
the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ Date ____ / ____ / ____ Witness _____

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement and in effect protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish of cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature _____ Date ____ / ____ / ____ Witness _____

Consent For Treatment of Minor

I hereby authorize _____ D.C. and whomever he/she may designate as his/her assistant(s) to perform diagnostic test including but not limited to radiographs and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____
_____ (Child's Name) _____

Guardian's Signature _____ Date ____ / ____ / ____ Witness _____

X-Ray/Medical Records Release

I have requested the release of records of (Patient's Name) _____ which are a part of the records at (Facility) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:		
Patient Address:		
Medical Record #:		Date of Birth: MM / DD / YY
Other Identifier (Social Security Number):		
"I hereby authorize this practice to make uses and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below."		
THIS INFORMATION IS TO BE DISCLOSED TO: Name of entity:		
Attention of:		
Street address of entity:		
City:	State:	Zip:
DESCRIPTION OF INFORMATION TO BE DISCLOSED:		
REASON FOR REQUESTED USE OR DISCLOSURE:		

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely.
e. No one has pressured me to sign this authorization.
f. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
h. I have received a copy of this authorization.

Patient Signature:		Date:
Signature of Patient's Representative:	Relationship:	Date:

FOR OFFICE USE ONLY

Event or Date Upon Which Authorization Will Expire: