Mason Spine and Injury Center

Please complete all fields of the form. Indicate N/A for questions that do not apply. Thank You.

Patient Registration

Patient: _____Birthdate:_____

Address: _____ City: _____ State _____ Zip: _____

Social Security Number: _____-_____-_____ Email: _____

Home PH: _____ Cell: _____ Cell phone carrier: _____

Occupation: _____ Employer:_____

Insurance Information

Primary Health Insurance Company: _____

ID# _____ Group#_____

Name of Policy Holder: _____ Date of Birth: _____

Policy Holders Address: _____ Home Phone#: (____) _____

Work Phone#: (____) _____ Policy Holders Employer: _____

Relationship of Patient to Policy Holder: Self Husband Wife Child Other

Patient's Auto Insurance Company: _____ Claim Number:_____

Purpose of Appointment

What Brings you in today? _____

Date injury occurred or condition started: _____ How did injury/condition occur? ☐ Auto ☐ On the Job ☐ Other

Other Doctors seen for this condition: _____

Have you been treated for any health condition in the last year? Explain _____

PROFESSIONAL SERVICES CONSENT, RELEASE OF INFORMATION & INSURANCE INFORMATION:

I authorize the assignment of insurance benefits to the chiropractic office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand this chiropractic 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 chiropractic office will be credited to my account upon receipt. I understand I may receive a billing statement for insurance denial, professional fees that have been applied to my deductible, co-payments, or any balance due stated by insurance company as my responsibility. In the event that I receive payment for any services I agree to promptly remit payment to the chiropractic office. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible to payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable unless other arrangements were made in writing. I understand I am responsible for collections fees, court costs and reasonable attorney fees to collect unpaid accounts.

I hereby authorize and release my health records to this office upon request. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examinations, x-ray studies, chiropractic care or any clinic services that he deems necessary in my case: and further authorize him to disclose all or any part of my patient health records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinics charges, including and not limited to, hospital or medical services companies, workers compensation carriers, welfare fund, or the patients employer.

Patient /Guardian Signature: _____ Date: _____

Mason Spine and Injury Center

HEALTH QUESTIONNAIRE

Patient: _____ **Date:** _____

PLEASE MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING.

Musculoskeletal System

- ☐ Low back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Pain between shoulders
- ☐ Neck pain/stiffness
- ☐ Arm/wrist/elbow/problems
- ☐ Shoulder problems
- ☐ Leg Problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Loss of motion/movement
- ☐ Chest pain

Eye and Ear

- ☐ Eye infection / inflammation
- ☐ Vision problems
- ☐ Ear pain / discharge
- ☐ Hearing loss / noises

Genitourinary system

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

Female ONLY

- ☐ Hormonal problems
- ☐ Breast problems

Reproductive problems

Are you pregnant?

- ☐ **YES**
- ☐ **NO**
- ☐ **MAYBE**

Habits

- ☐ Cigarettes_____pk/day
- ☐ Coffee or tea____cups /day
- ☐ Soda_____#/day
- ☐ Drug abuse
- ☐ Alcohol abuse

Gastrointestinal System

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomit blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Weight trouble/changes

Nose & Throat

- ☐ Nose pain/bleed/discharge
- ☐ Mouth/throat sore/hoarse
- ☐ Sinus problems

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Cardiovascular & Respiratory

- ☐ Chest / heart pain
- ☐ Varicose veins
- ☐ Heart problems
- ☐ Hard to breathe
- ☐ Lung problems

What is your hand dominance?

L or R

Please indicate areas on this body where you feel the described sensations:

Numbness	Pins & Needles	Burning	Aching	Stabbing
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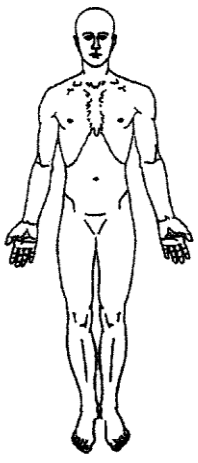

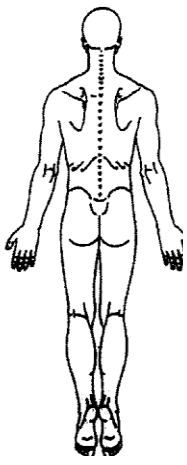

0= No Pain, 10= Severe Pain

Neck-Shoulder-Arm-Pain

0 _____ 10

Mid back Pain

0 _____ 10

Low Back and Leg Pain

0 _____ 10

Family History

Me	Family	
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Cancer
☐	☐	Epilepsy
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Concussion
☐	☐	Asthma
	☐	None Apply

Allergies: _____

Medications: _____

Over-the-Counter Medications (OTC) & Vitamins: _____

List all Surgeries or Hospitalizations: _____

Prior Illness or Injuries (Auto, Work, Etc.): _____

Other health conditions you presently suffer from: _____

Mason Spine and Injury Center

Patient Name: _____Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Mason Spine and Injury Center.** I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.
Please note that with any returned checks, there is a fee of $35.00

Print Name: _____

Signature: _____ Date: _____