CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr.______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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 services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

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

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (______) ______ Home Phone (______) ______

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

Attorney Name (if applicable) ______

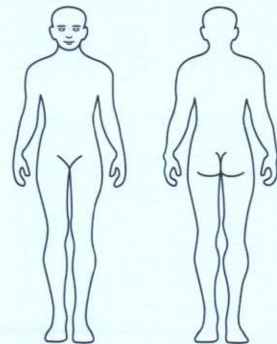
5 PATIENT CONDITION

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? ______

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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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:

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

MOSS BLUFF CHIROPRACTIC CLINIC
INFORMED CONSENT

Doctors of Chiropractic seek to restore health by treating the underlying cause of your condition(s). Our Chiropractors choose to work with the body's own healing potential, using conservative treatments, rather than use harsh drugs and surgery.

The success of your care depends on the extent of injury. Your compliance to the doctors given treatment plan, as well as any underlying physical conditions.

You are encouraged to take an active role in your chiropractic treatment plan, as well secure other opinions if necessary. You are responsible for the decisions regarding yo health.

By coming to a Doctor of Chiropractic you have given the doctor your permission and authority to care for the Patient in all test, procedures, and treatment plan(s).

In general, but not mandatory, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures.

These include:

1. **Stroke:** Stroke is the most serious problem associated with spinal manipulation The results can be temporary or permanent dysfunction of the brain, with rare complications of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusive data to quantify probability).

2. **Disc Herniation:** Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3. **Soft Tissue injury**: Soft tissue primary refers to muscles and ligaments. Muscles move the bones and ligaments limit joint fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

4. **Rib Fractures**: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weekend bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

UNDER THESE RISK FACTORS, I CANNOT HOLD MOSS BLUFF CHIROPRACTIC CLINIC/ DR. CHAD RICHARD, LIABLE FOR ANY OF THE MENTIONED RISKS WHICH COULD HAPPEN.

Congratulations, on choosing the safe natural healthcare of the 21st century!

ACKNOWLEDEMENT RECIEPT FOR NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the NOTICE OF PRIVACY PRACTICES detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

**I have read and understand the foregoing.*

Patient Signature	Date
Print	RELATIONSHIP (if signed by guardian)
CA Signature	Date
Physicians signature	Date / Time

RELEASE FORM

Allowable contact by Email /Text /Phone
Use of Testimonial (Written/Video/Photo)

Being a Health Care Provider, one of our top priorities is to protect you and your private health information (PHI). We go to great lengths to ensure that your PHI is well protected.

As well, at "Moss Bluff Chiropractic Clinic", we are passionate about clear communication and transparency. By supplying education, to help support your needs, as well as educate your family, friends and neighbors regarding healthy lifestyle changes and our services, everybody wins! This information causes us all to work harder at being healthy, helps us make better life decisions, and builds healthier communities.

As you know, we live in an ever increasingly technological age that exchanges information via cell phones, social media and internet-based activity. We have all made changes in how we connect and communicate. This advanced ability to communicate has created wonderful opportunities to create a global community, but also opens possibilities for misuse of these options. We want to communicate with you in a way that is convenient and comfortable for YOU! Please let us know you preferences below:

Authorization for Release of Information

We are requesting your permission for Moss Bluff Chiropractic Clinic to communicate with you in the following ways:

1) **I authorize Moss Bluff Chiropractic Clinic to call/fax and/or leave voice or text messages, that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc. -at the following phone number/numbers ;**
   ____________, ____________,____________.
   ______ **Initial here for your consent**

2) **I authorize Moss Bluff Chiropractic Clinic to utilize the following email addresses to send messages that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc.;**
   Email addresses: ____________________, ____________________,____________.
   ______ **Initial here for your consent**

TESTIMONIALS

3) **I choose to give a patient testimonial** for the purpose of, but not limited to, the publication or promotion of my thoughts, feelings, and experiences, as they relate to "Moss Bluff Chiropractic Clinic, Dr Chad Richard, and /or staff.

   I understand my testimonial/review, made on behalf of Moss Bluff Chiropractic Clinic, may be used in connection with publicizing and promoting Moss Bluff Chiropractic Clinic. I authorize Moss Bluff Chiropractic Clinic to use my name, brief biographical information, and the Testimonial/Review, as well as any photographs of me. The effective date is the first day of any services provided by Moss Bluff Chiropractic Clinic, Dr Chad Richard, and /or staff.

   I hereby irrevocably authorize Moss Bluff Chiropractic Clinic to copy, exhibit, publish or distribute pictures, video and/or my written Testimonial/Review for purposes of publicizing Moss Bluff Chiropractic Clinic's programs or for any other lawful purpose. These statements, photos or videos may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Moss Bluff Chiropractic Clinic for the use of the statement, testimonials/reviews, video or pictorial representations of me. In addition, I waive any right to inspect or approve the finished product, including written copy or edited video wherein my likeness or my testimonial appears. I hereby hold harmless and release Moss Bluff Chiropractic Clinic from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons, acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.

   ______ **Initial here for your consent**

I have read the information above and authorize the initialed sections.

Signature: ____

Printed Name: ____

Email: ____

Address: ____

City, State, Zip: ____

Cell phone: ____________________________ Date: ____________

Moss Bluff Chiropractic Clinic
P.O. Box 12571
Lake Charles, LA 70611
Phone: (337) 855-6306

To the Patient:

- You must present your insurance card on the first visit or the date you acquired your insurance.
- If you have any changes in insurance, it is your responsibility to notify our office of the changes.
- It is in the patient(s) best interest to inform our office if you were in a work- related accident or automobile accident.
- If you obtain an attorney due to a work-related injury or automobile accident, you must inform our office as soon as possible.
- You will be financially responsible for any charges incurred for treatment if information is not given.

______________________________ ______________________________

SIGNATURE **DATE**

Moss Bluff Chiropractic Clinic

CHAD RICHARD, D.C.

P.O. BOX 12571
119 TAHOE ROAD
LAKE CHARLES, LA 70611
TELEPHONE: (337) 855-6306

RELEASE OF INFORMATION

I hereby authorize ________________________________ to release to Dr. Chad Richard, D.C. any and all medical information in my records.

____

Patient D.O.B SSN#

______________________________ ______________________________

Patient Signature Parent/Guardian

____

Date

____

Witness

CONFIDENTIALITY NOTE: THE INFORMATION CONTAINED IN THIS FACSMILE MESSAGE IS LEGALLY PRIVILEGED AND CONFIDENTIAL INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAME ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPENT, YOU ARE HEREBY NOTIFIED THAT NAY DISSEMINATION, YOU HAVE RECEIVED THIS TELECOPY IN ERROR PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND DETROY THE TELECOPY.

IF ANY PROBLEMS OCCUR DURING THIS TRANSMITTAL,
PLEASE CALL (337) 855-6306