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) _____

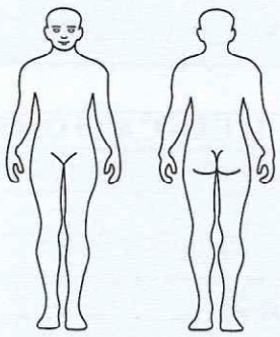
5 PATIENT CONDITION

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

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	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 and 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 i r i secure other opinions if necessary. You are responsible for the decisions regarding your 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 Herniation that create pressure on the spinal nerve o spinal cord are frequently successfully treated by chiropractors.

Rarely, treated by chiropractors, treatment may aggravate the problem, resulting in an increased low back pain, ridiculer 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

_____ _____

Patient name (Print) RELATIONSHIP (if signed by guardian)

_____ _____

CA Signature Date

_____ _____

Physician's 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 al 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_____

Moss Bluff Chiropractic Clinic
P.O. Pox 12571
Lake Charles, LA 70612
Phone: (337) 855-6306

To the Patient:

- You must present you 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 an 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.
PO Box 12571
Lake Charles, LA 70612
Telephone: (337) 855-6306

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

_____ _____ _____
Patient (Print) D.O.B. SSN#

_____ _____
Patient Signature Parent/Guardian

_____
Date

_____
Witness

Confidentiality note:
The information contained in this facsimile message is legally privileged and confidential intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that nay dissemination, you have received this telecopy in error please immediately notify us by telephone and destroy the telecopy.

If any problems occur during this transmittal, please call (337) 855-6306