CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____

Last Name: _____

First Name: _____

Address: _____

City: _____
State: _____
Zip: _____
Phone: _____
Date of Birth: _____
Age: _____
Birth Sex (For Anatomical/medical Reasons):
☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Non-Binary

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

Occupation: _____

Whom may we thank for referring you?

_____

INSURANCE INFORMATION

Insurance Card and ID will be scanned in the office. If you do not have your insurance card please fill form below:
Insurance Co.: _____
ID #: _____
Group#: _____
Subscriber Name if Not yours: _____
Subscriber date of Birth if NOT yours: _____

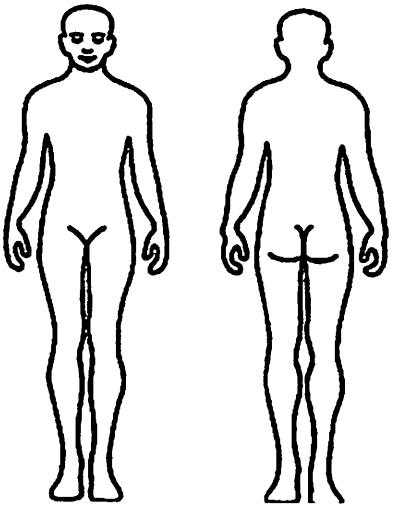
IS THIS VISIT FOR AN AUTO/WORK INJURY?
☐ Yes ☐ No
If YES, please fill out Auto Accident Injury Intake form or request Work Comp Injury Form.

PATIENT CONDITION

When did the symptoms appear? _____

Is this condition getting worse? ☐ Yes ☐ No

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____
Type of Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Throbbing
☐ Stiff ☐ Dull ☐ Shooting ☐ Burning ☐ Cramps
How Often do you have this pain? _____
Is it constant or does it come and go? ☐ **Constant** ☐ **Intermittent**
Activities or movements that are hard to perform:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Sitting
☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Mark an X all areas that you feel pain

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

Have you had recent imaging?(MRI, CT, X-Rays) ☐ Yes ☐ No

If Yes, where were they taken? _____

Please Mark with an X to indicate if you have had the following:

Aids/HIV	Diabetes	Liver Disease	Scarlet Fever
Alcoholism	Emphysema	Measles	STD
Allery Shots	Epilepsy	Migraines	Stroke
Anemia	Fractures	Multiple Sclerosis	Thyroid Problems
Anorexia	Glaucoma	Mumps	Tonsillitis
Appendicitis	Goiter	Osteoporosis	Tuberculosis
Arthritis	Gout	Pacemaker	Tumors/Growths
Asthma	Heart Disease	Parkinson's	Typhoid Fever
Bleeding Dsrdr.	Hepatitis	Pinched Nerve	Ulcers
Breast Lump	Hernia	Pneumonia	Whooping Cough
Bronchitis	Herniated Disc	Polio	Lyme Disease
Cancer	Herpes	Prostate Problem	Are you Pregnant?
Cataracts	High Blood Pressure	Rheumatoid	
Chicken Pox	Kidney Disease	Rheumatic Fever	

EXERCISE	WORK ACTIVITY	HABITS
None	Sitting	Smoking- Packs Per day:
Moderate	Standing	Drinking-Drinks per Week:
Daily	Light Labor	Coffee/Caffeine-Drinks/Day:
Heavy	Heavy Labor	High Stress

Injuries/Surgeries you have had:

Falls: _____ Date: _____
Head Injuries: _____ Date: _____
Broken Bones: _____ Date: _____
Dislocations: _____ Date: _____
Surgeries: _____ Date: _____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHIROCENTRIC LLC 14355 SW Allen Blvd. Ste. 150
BEAVERTON OR 97005

CHIROCENTRIC
Chiropractic-Acupuncture-Massage Therapy
114355 SW Allen Blvd. STE 150
Beaverton, OR 97005
503-806-5700

Eligibility Guarantee:

I, _____ herby certify that I am eligible for Chiropractic, Acupuncture, and/or Massage Therapy benefits offered by my insurance either provided by myself, employer, spouse, or auto.

I understand that if the above is not true, or if I am not eligible under the terms of my Medical/Hospital Subscriber agreement, or Auto Insurance Policy, that I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Chirocentric.

I also understand that under this policy I am responsible for whatever portion my insurance company does not pay, including the yearly deductible (if applicable to my insurance plan).

Assignment of Benefits:

I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to Chirocentric who accepts assignment.

_____ _____

Date Signature of Patient (Subscriber)

ChiroCentric, L.L.C.
Kimberly DeAlto, D.C.
14355 SW Allen Blvd. STE 150
Beaverton, OR 97005

Telephone: (503) 806-5700

INFORMED CONSENT TO CHIROPRACTIC CARE

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the above named doctor of chiropractic.

Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of health care, there are some risks. These can include but are not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have had the opportunity to discuss with the doctor the purpose, benefits and risks of the recommended chiropractic care and alternatives to chiropractic treatment have been reviewed.

I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made. I have had ample opportunity to ask questions and my questions have been answered to my satisfaction.

Patients name (Printed) _____ Date _____

Signature of Patient: _____

OR

Signature of Parent/Guardian _____
(If patient is a minor)

ChiroCentric, L.L.C.
Kimberly DeAlto, D.C.
14355 SW Allen Blvd. STE 150
Beaverton, OR 97005
(503) 806-5700

OFFICE POLICIES

To prevent any misunderstandings about your insurance coverage and my billing/collections procedures, I would like to inform my patients that I could not render services on the **ASSUMPTION** that my charges will be paid by an insurance company. You will be fully responsible for all professional services furnished that your insurance company does not pay. Benefits given by your insurance company, over the phone, are quotes of coverage and not absolute coverage.

As a courtesy to my patients, I will bill your insurance company and benefits will be assigned directly to this office. **YOU ARE RESPONSIBLE** to know what your insurance covers prior to me calling. It is the policy of this office to:

1. Receive full payment for services rendered from patient paying at the time of service (Cash, Check, or Credit Card). When you pay at the time of service you get a 20% discount. If you wish to be billed later you will be billed at my regular rate. If you wish to see a list of my rates please ask and the office will supply you with those details.
2. Collect insurance co-payments on the same day services are rendered.
3. A $75 cancellation fee will be applied if given less than 24 hours notice of a cancelled or no show for a Chiropractic appointment. An $80 charge will apply for cancellations/no-call no-show for massage therapy/manual therapy appointments.
4. Bill a 10% delinquency charge if payment is not received prior to the next monthly billing. (Any bill over 30 days late)
5. A $30.00 fee will be charged for all returned checks.
6. In some cases your insurance company will send you the check for services rendered in this office. You agree, upon receipt of a check, that you will endorse it and send it/deliver it to my office with the Explanation of Benefits attached. You are responsible to pay your balance within 30 days of when service is rendered whether it be a check from your insurance company or a personal account. 7. There is no refund on orthotics after the 45 day break in period.

Please sign and date this policy form. Your signature will signify your understanding and compliance with ChiroCentric Office Policies.

Printed Name: _____ Signature_____

Date_____