

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 _____

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) _____

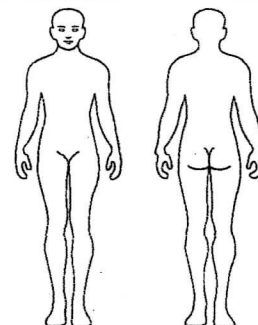
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____) _____

ERICKSON CHIROPRACTIC & WELLNESS CENTER

650 OGLETHORPE AVE
SUITE 4
ATHENS, GA 30606
(706)-353-7778

INFORMED CONSENT FOR CHIROPRACTIC CARE

PATIENT _____

I hereby request and consent to performance of the procedures within the scope of Chiropractic including, but not limited to, adjustments, X-ray procedures, and various forms of physical therapy and supplementation from the Doctors of Chiropractic associated with, employees of assistants employed by the Doctors, or Chiropractors filling in for any Doctors listed in the practice listed above.

Someone from the above practice has discussed and I understand the nature and purpose of Chiropractic adjustments and other therapies used at Erickson Chiropractic. I understand and have been informed that there are some risks involved in Chiropractic treatments such as, but not limited to, the possibility of: fractures, disc injury, strokes, dislocations, and sprains. I wish to rely on the Doctors knowledge and judgement during the course of the procedures now and in the future as long as I am under care at this practice, which the Doctor feels at the time, based on the facts known is in the best interest of me.

I have read, or have had the above consent information read to me, and have had the opportunity to ask any questions to clarify the content, and by signing below, I agree to the named procedures. I intend this content form to cover the entire course of treatment for my present condition and for any conditions in the future.

Signature of patient

Date

Witnessed by

Date

NOTICE OF PRIVACY FOR PATIENTS PROTECTED

HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy. This office uses and discloses your protected health care information for the following reasons:

- To share with other treating healthcare providers regarding your health care.
- To submit to Medicare to verify that treatment has been rendered.
- To determine patient's benefits in a Medicare plan.
- Releasing information required by State or Federal public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Inspect, copy and amend your protected health information as allowed by law.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient Signature

Date

OFFICE COPY

Insurance: Although we are in-network preferred providers for most health insurance companies, your policy is ultimately your responsibility. Your insurance is a contract between you and your insurance company. There are many different policies that exist. Due to issues with verification of insurance coverage, we prefer not be held accountable for what your insurance covers and does not cover. Most times we have verified this insurance with 100% accuracy; however problems have arisen in the past. Our office will notify you when we think there is a policy that we do not understand.

_____ Initial I have read and understand that my insurance is ultimately my responsibility.

Appointments:

Currently we set standard office visits at 3 people in each 30 minute time slot. These times are reserved specifically for you. If you have an appointment set, nobody else is allowed to schedule at that time. If you do not make your appointment, this ends up being a time when someone else may have wanted that time, but was unavailable because we were holding it for you. We strive to respect your time as much as possible by seeing you at your scheduled appointment time. It is appreciated that you respect our time as well. Our office policy states you should give 24 hours notice to reschedule appointment. If your appointment is less than 24 hours away, please call us as soon as possible if you need to cancel or move your appointment. Most times if you call within a few hours of your appointment to cancel the appointment, the doctor will approve a waiver on your missed appointment fee up to a max of 2 times.

If you are late for an appointment, you risk being seen after people who made their appointment and were on time.

If the above criteria are not met, a \$25.00 charge will be billed to your account and must be paid directly from you (this will not be billed to insurance, personal injury, or workman's compensation cases.) If you discontinue care at this office, a bill will be mailed to you for this fee. If this bill is not paid within 30 days, we will be prompted to send you to collections.

_____ Printed Name ___/___/___ Date

_____ Signature

_____ Witness ___/___/___ Date