CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age___ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Spouse's Name_____

Spouse's Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_ _____

Relationship to Patient_____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to ~~Peters Ch.~~ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Cell phone_____

Work_____ Ext____

Best time and place to reach you _____

E-mail Address_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No

If yes, when did the accident occur? _____

Type of accident? ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Work Comp. ☐Other

Attorney Name (if applicable)_____

_____

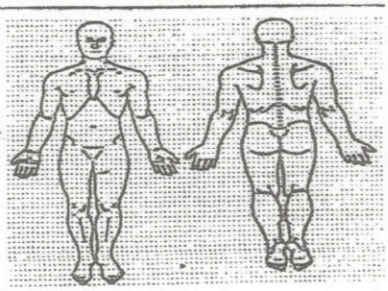
5 PATIENT CONDITION

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 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	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Suicide attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors/Growth	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Vaginal Infection	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	_____		
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ 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

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Peters Chiropractic

Sports Therapy, Acupuncture and Massage Therapy

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Peters Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Peters Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

_____

Patient's Name (Please Print) Date

_____

Patient or Guardian's Signature

Peters Chiropractic

Sports Therapy, Acupuncture and Massage Therapy

Financial Policy and Agreements

We are excited to have you as a patient here at Peters Chiropractic for your Chiropractic, Acupuncture, and Sports Therapy healthcare provider! We pride ourselves in providing the best diagnostic and integrated healthcare with many convenient payment options. At the time of your first visit, we require presentation of the patient's most recent insurance card, valid I.D., and credit card.

Insurance We are happy to bill your insurance for you as a courtesy. We will verify your insurance coverage for you here at our office and then alert you of your in and out of network coverage including services, deductibles, copayments, and percentage of coverage. It is your responsibility to notify our office in the event of any change in your insurance, address, phone numbers, etc. If the insurance payments do not cover our minimum cash prices, you are ultimately responsible for the fee differences.

PLEASE NOTE: Your Company may send payment checks directly to you that are actually due to our office to compensate for our services. If we determine this to be the case, the following steps must be taken:

- Call the insurance customer service number to request "a PPO Waiver". This will relieve you of the burden of waiting for and writing over these checks to our office. **Anthem: 1(800) 521-2227**
- If you received a check(s) made out to you, endorse them to our office (Peters Chiropractic), or reimburse us with cash or check. Credit card payments will be subject to a 3-4% processing fee.
- The insurance company alerts us when checks are received. We will then provide you with two weeks from that time to reimburse our office before we are to charge your card.

Many of our patients choose not to use their insurance due to high deductibles and co-pays. Discounted cash wellness packages are available.

Cash Cash patients must pay in full at the time of service for Chiropractic, Acupuncture, Sports Therapy and Massage Therapy sessions. To keep our cash prices low, cash is preferred in lieu of checks or credit cards. Discounted cash wellness packages are available.

Personal Injury Cases We will make every attempt to work with Personal injury cases on a lien basis. Upon receiving all information about your accident, we will contact your insurance claim officer and/or attorney to determine the risk of your case. If the case is justified, we will continue care with no upfront charge to you. If at the end of treatment, the third party payment does not satisfy our minimum cash prices, you will be responsible for the difference owed.

Delinquent Accounts Accounts that are not paid in full or satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Our billing department will first provide ample notice to you of accounts we consider delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, or to an attorney for further action.

Appointment Cancellation Policy In order to provide you and other patients with the best optimal care, your appointment time is reserved solely for you, for up to 30 minutes. Not showing for this set appointment denies other patients a potential treatment slot. We request a 24 hours notice to reschedule your appointment (chiropractic, acupuncture, sports or massage therapy incl.). You will be charged a **$20 reservation fee** for same day cancelations.

Credit Cards on File It is our policy to keep current credit card information on file. We prefer not to use your credit card, but will do so as a final attempt to collect on delinquent accounts. Your information will be locked and confidential. Fees will be 3-4% more than our offered cash prices.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice. I have read, understand, and agree to the above Financial Policy.

_____ _____ _____

Name Signature Date

Peters Chiropractic

Sports Therapy, Acupuncture and Massage Therapy

Policy Regarding Massage and/or Personal Training

We are pleased to offer you massage therapy and personal training options here at Peters Chiropractic as well! We will verify your insurance coverage for you here at our office and then alert you if your coverage includes massage or personal training. For those that do not have insurance coverage, we offer terrific cash prices or packages.

We schedule our therapist and trainers on an individual basis to meet your needs. Therefore, appointments are necessary and very important. They can be made through our office. We have a strict 24-hour cancelation policy if you cannot make your appointment. We understand things come up and we will do our best to re-schedule. However, if you must cancel on the same day as your appointment, we will charge a $20 fee to cover the cost of the trainer or therapist.

Please sign below in agreement with the above policy.

_____ _____

Name Date