Bath City Chiropractic Clinic

Registration and History Form

PATIENT INFORMATION

Date: _____/_____/_____

Patient _____

Address _____

_____
City State Zip

Sex □ M □ F Age _____ Birthdate _____

Occupation _____

Employer _____

Spouse's Name _____

Sex □ M □ F Age _____ Birthdate _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

PHONE NUMBERS/ EMAIL

Cell _____ Provider_____

Home _____ Work _____

Email _____

Best time / place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone Number _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ڤ Yes ڤ No

Subscriber's Name _____

Birthdate _____ SS# _____

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 Dr. McFadden 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 forms.

Responsible Party Signature

Relationship Date

ACCIDENT INFORMATION

Is this 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?

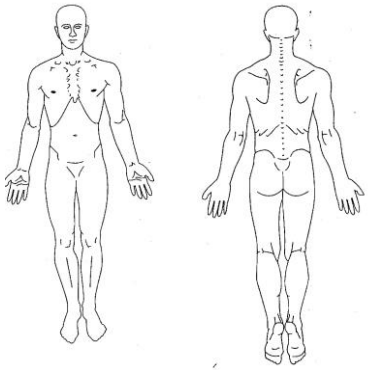
□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable) _____

Bath City Chiropractic Clinic

PATIENT CONDITION

Reason for visit



_____

When did this symptom 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?_____

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

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

HEALTH HISTORY

What treatment have you already received for your condition? □Medications □Surgery □Physical Therapy □Chiropractic Service □None □Other _____ Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of last exam: Physical Exam _____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray_____ Urine Test_____
Dental X-ray_____ MRI, CT-Scan, Bone Scan _____

Check only those conditions that are applicable:

□ AIDS / HIV	□ Diabetes	□ Measles	□ Rheumatic Fever
□ Alcoholism	□ Emphysema	□ Migraine Headache	□ Scarlet Fever
□ Allergy Shot	□ Epilepsy	□ Miscarriage	□ Stroke
□ Anemia	□ Fractures	□ Mononucleosis	□ Suicide Attempt
□ Anorexia	□ Glaucoma	□ Multiple Sclerosis	□ Thyroid Problems
□ Appendicitis	□ Goiter	□ Mumps	□ Tonsillitis
□ Arthritis	□ Gonorrhea	□ Osteoporosis	□ Tuberculosis
□ Asthma	□ Gout	□ Pacemaker	□ Tumors, Growths
□ Bleeding Disorders	□ Heart Disease	□ Parkinson's Disease	□ Thyroid Fever
□ Breast Lump	□ Hepatitis	□ Pinched Nerve	□ Ulcers
□ Bronchitis	□ Hernia	□ Pneumonia	□ Vaginal Infections
□ Bulimia	□ Herniated Disk	□ Polio	□ Venereal Disease
□ Cancer	□ Herpes	□ Prostate Problem	□ Whooping Cough
□ Cataracts	□ High Cholesterol	□ Prosthesis	□ Other _____

□ Chemical Dependency □ Kidney Disease □ Psychiatric Care □ _____ □ Chicken Pox □ Liver Disease □ Rheumatoid Arthritis □ _____

EXERCISE	WORK ACTIVITY	HABITS	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ 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	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____ _____ _____ _____ _____ Pharmacy_____ Name _____ Pharmacy Phone _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Bath City Chiropractic Clinic

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alterations of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of non-chiropractic findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I understand that chiropractic treatments have minimal inherent risk associated with the nature of the therapy. Including but are not limited to: sprains, strains, dislocations, fractures and strokes. I am fully aware of the risk. I consent to the treatments and all risk associated with the treatments.

I, _____ being the parent or legal guardian of _____, hereby grant permission to Dr. McFadden, Bath City Chiropractic Clinic to evaluate and treat _____.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

I, _____ have read and fully understand the above statements.
(please print your name)

_____ _____
(signature) (date)

Bath City Chiropractic Clinic

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Bath City Chiropractic Clinic PLLC** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Bath City Chiropractic Clinic PLLC** Notice of Privacy Practices prior to signing this document. **Bath City Chiropractic Clinic PLLC** Notice of Privacy Practices can been provided to me, upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Bath City Chiropractic Clinic PLLC**. A copy of the Notice of Privacy Practices for **Bath City Chiropractic Clinic PLLC** is on display in the common waiting area of this practice. This Notice of Privacy Practices also describes my rights and **Bath City Chiropractic Clinic PLLC** duties with respect to my protected health information.

Bath City Chiropractic Clinic PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Bath City Chiropractic Clinic PLLC

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Please Print
Clearly

1. Name (Last, First) _____
2. Email address: _____@_____
3. Preferred method for patient reminders **(Circle one): Email / Phone / Mail**
4. DOB: __/__/____
5. Gender **(Circle one): Male / Female**
6. Preferred Language: _____
7. Smoking Status (**Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked**
8. Family Medical History - Record ONE DIAGNOSIS in your Family History

   Who & DX (Ex. – Mom – Stroke) _____
9. Race **(Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer**
10. Ethnicity **(Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer**
11. Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

12. Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

1. I choose to **(circle one) decline/accept** receipt of my clinical summary after every visit.
   (These summaries are often blank because of the nature and frequency of chiropractic care.)
2. Patient Signature: _____ Date: _____

<u>For office use only</u> Height: _____ Weight:_____ Blood Pressure:_____ /_____