

# CHIROPRACTIC REGISTRATION & HISTORY

## PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Separated  Widowed  Divorced  
 Single  Minor  Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone ( ) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

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 \_\_\_\_\_ Name of Insurance Company(ies) 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

## PHONE NUMBERS

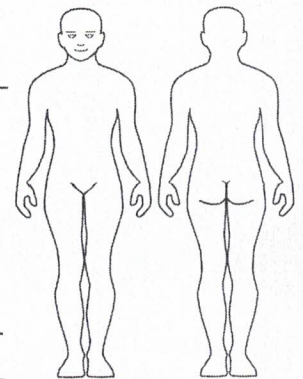
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 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's Comp.  Other  
Attorney Name (if applicable) \_\_\_\_\_

## 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



# 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 | Chicken Pox      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy         | <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 | Fractures        | <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 | Glaucoma         | <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 | Goiter           | <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 | Gonorrhea        | <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 | Gout             | <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 | Heart Disease    | <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 | Hepatitis        | <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 | Hernia           | <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 | Herniated Disk   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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 | Other                | <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 |                     |  |                      |  |

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 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 (\_\_\_\_\_) \_\_\_\_\_



**Authorization to Receive Information**

I hereby grant permission to disclose and/or release all information and records regarding my treatment, diagnostic reports, X-ray reports and consulting reports. Please send copies of my records to:

**Chapman Health Group  
32749 Radio Road  
Leesburg, FL 34788  
352-728-6886**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Release Information**

I hereby authorize the release of any information to my health care companies, Medicare or legal representative with a Request Authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Treat a Minor Child**

I hereby request and authorize Chapman Health Group to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child. As of this date, I have the legal right to select and authorize health care services for the minor child named above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Pregnancy Warning and Release**

I understand that in the event that I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-rays. With the full understanding of the above and believing that I am not pregnant or at risk, I wish to have an examination which may include X-rays.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Chapman Health Group**  
**32749 Radio Road**  
**Leesburg, FL 34788**

**Tel: 352-728-6886**  
**Fax: 352-728-0823**

### **Acknowledgment Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

**Chapman Health Group**  
**32749 Radio Road**  
**Leesburg, FL 34788**

**Tel: 352-728-6886**  
Fax: 352-728-0823

**Consent to Use or Disclose Information for Treatment,  
Payment or Health Care Operations**

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Chapman Health Group, (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:  
(Patient must fill out) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please initial, do not check, the appropriate categories listed below):

- \_\_\_\_\_ HIV/AIDS Information \_\_\_\_\_
- \_\_\_\_\_ Mental Health Information \_\_\_\_\_
- \_\_\_\_\_ Substance Abuse Information \_\_\_\_\_
- \_\_\_\_\_ Sexually Transmitted Disease Information \_\_\_\_\_
- \_\_\_\_\_ If Patient is under the age of eighteen (18), Pregnancy Information \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_



Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial, do not check**, the appropriate spaces below):

- \_\_\_\_\_ Via e-mail to the Patient's designated e-mail address which is:  
\_\_\_\_\_
- \_\_\_\_\_ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.
- \_\_\_\_\_ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, CHG will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATE TERMS.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Signature of Patient/Authorized Representative\*

\_\_\_\_\_  
Please Print Name

\*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



A. Notifier:  
B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New patient exam Therapy (EMS / traction) X-Rays	Not covered by Medicare and/or not covered bc we are a chiro	\$ 85 \$ 12 \$ 90 - \$ 120

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:

J. Date:

**You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.