## Lake Superior chiropractic

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| (Temporary Form - New One Will Be Uploaded Shortly)  (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | | | Middle: | | | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | | | | Marital status (circle one) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | | |
| Is this your legal name? | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | | Birth date: | | | | | | | | Age: | | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | / / | | | | | | | |  | | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | |
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| P.O. box: | | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | ZIP Code: | | | | | | | | | |
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| Occupation: | | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
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| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
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| Is this person a patient here? | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
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| Is this patient covered by insurance? | | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | | | | ❑ [Insurance] | | | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | | | ❑ [Insurance] | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | ❑ [Insurance] | | | | | |
| ❑ [Insurance] | | | | | ❑ [Insurance] | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | | ❑ Welfare (Please provide coupon) | | | | | | | | | | | | | | | | | | | ❑ Other | | | | |  | | | | | | | | |
| Subscriber’s name: | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | | Birth date: | | | | | | | | | Group no.: | | | | | | | | | | | | Policy no.: | | | | | | | | | Co-payment: | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | Policy no.: | | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | Work phone no.: | | | | | | | |
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| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lake Superior chiropractic or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | | | | |  |

ABOUT YOU: (please check all that apply)

**Chiropractic Experience:**

Who referred you to our office?

Where did you hear about us?

* Newspaper
* Sign
* Yellow Pages
* Community Event
* Mailing

Have you been adjusted by a chiropractor before?

* Yes
* No

If yes, what was the reason for those visits?

Doctor’s name:

Approx. date of last visit:

Has any adult in your family ever seen a chiropractor?

**Reason for this Visit:**

Describe the reason for this visit:

Is the purpose of this appointment related to any of the following:

* Job
* Sports
* Auto
* Fall
* Home injury
* Chronic discomfort
* Other

Please explain further:

If job related, have you made a report of your accident to your employer?

* Yes
* No

When did this condition begin?

Has this condition

* Gotten worse
* Stayed constant
* Come and gone

Does this condition interfere with:

* Work
* Sleep
* Daily routine
* Other activities

Please explain further:

Has this condition occurred before?

* Yes
* No

Please explain further:

Have you seen other doctors for this condition?

* Yes
* No

Doctor’s name:

Type of Treatment:

Results:

**Goals for your care:**

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

* **Relief care:** Symptomatic relief of pain or discomfort
* **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom
* **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
* ***I want the Doctor to select the type of care appropriate for my condition.***

**Allergies/Medications:**

**Please provide specific names**

**Your Concerns:**

*Instructions: Please check the health concerns or conditions you may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.*

* Headaches
* Migraines
* Dizziness
* Sinus Problems
* Allergies
* Fatigue
* Head colds
* Vision problems
* Difficulty concentrating
* Hearing problems
* Sore throat
* Stiff neck
* Radiating arm pain
* Hand/finger numbness
* Asthma
* High blood pressure
* Heart conditions
* Middle back pain
* Congestion
* Difficulty breathing
* Bronchitis
* Pneumonia
* Gallbladder conditions
* Stomach problems
* Ulcers
* Gastritis
* Kidney Problems
* Constipation
* Colitis
* Diarrhea
* Gas pain
* Irritable bowel
* Bladder problems
* Menstrual problems
* Low back pain
* Pain or numbness in legs
* Reproductive problems
* Other:

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**Health Conditions:**

*Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.*

* Severe or frequent headaches
* Heart surgery/pacemaker
* Lower back problems
* Digestive problems
* Pain between shoulders
* Congenital heart defect
* Frequent neck pain
* Thyroid problems
* Sinus problems
* Hepatitis
* Difficulty breathing
* Kidney problems
* Dizziness
* Chemotherapy
* Pain in arms/legs/hands
* Low blood pressure
* Rheumatic fever
* Ulcers/colitis
* Tuberculosis
* Arthritis
* Shingles
* Numbness
* High blood pressure
* Diabetes
* Surgeries (please specify):

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* Asthma
* Loss of sleep

**Women Only:**

* Are you pregnant?

Due date: \_\_\_\_\_\_\_\_\_\_

* Are you nursing?
* Are you taking birth control?

Do you:

* Experience painful periods
* Do you have irregular cycles?
* Do you have breast implants?

**Authorization for Care / Terms of Acceptance**

*I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.*

*I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor’s Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor’s Office will be credited to my account on receipt.*

***Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.***

***A fee of 1% will be added to accounts over 4 months. All LIENS will be honored.***

We do not offer to diagnose or treat ay disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. 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 subluxation.

*I have read and fully understand the above statement. Any 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.*

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

* PATIENT
* SPOUSE
* PARENT
* WORKERS COMP
* **Supplemental Accident Insurance**
* AUTO INSURANCE
* MEDICARE
* HEALTH INS

***NOTICE OF PRIVACY POLICY***

*Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.*

*You may request restrictions on your disclosures.*

*You may inspect and receive copies of your records within 30 days with a request.*

*You may request to view changes to your records.*

*In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.*

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

*Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*

*Obtain payment from third party payers.*

*Conduct normal healthcare operations such as quality assessments and physician’s certification.*

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| AUTHORIZED SIGNATURE: | DATE: |