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) _____

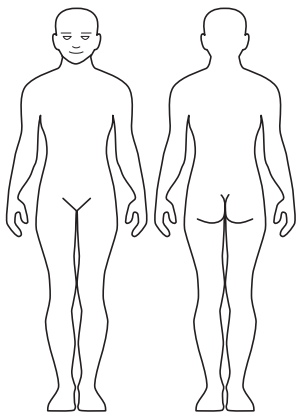
PATIENT CONDITION

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

MEDICATIONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (_____)_____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

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: _____

Vehicle Accident Information

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____AM/PM

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy

Which direction were you headed? _____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in: _____

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

(IF APPLICABLE)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No

If yes, explain _____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Yes ☐ No

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of Hospital _____ Name of Doctor _____

Diagnosis _____

_____

Treatment received _____

_____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many days have you missed?_____

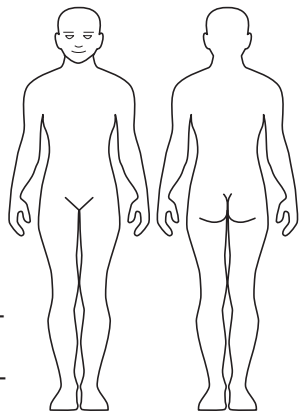
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck Pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

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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I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

Chapman Health Group
32749 Radio Road
Leesburg, FL 34788

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

PATIENT IS TO INITIAL EACH THERAPY PERFORMED AND SIGN THE LOG AT THE END OF THE FORM.

PIP PATIENT LOG

Patient's Name ____ Claim No. _________________________

___Office Visit	___Hot/Cold Pack	___Gait Training
___ Manual Therapy	___Whirlpool	___Functional Activities
___ Therapeutic Exercises	___Electrical Stimulation	___Spinal Manipulation
___ Therapeutic Ultrasound	___Cervical Traction	___Extremity Manipulation
___ Massage Therapy	___X-Rays	

Date of Service _________________________ Patient's Signature ____

___Office Visit	___Hot/Cold Pack	___Gait Training
___ Manual Therapy	___Whirlpool	___Functional Activities
___ Therapeutic Exercises	___Electrical Stimulation	___Spinal Manipulation
___ Therapeutic Ultrasound	___Cervical Traction	___Extremity Manipulation
___ Massage Therapy	___X-Rays	

Date of Service _________________________ Patient's Signature ____

___Office Visit	___Hot/Cold Pack	___Gait Training
___ Manual Therapy	___Whirlpool	___Functional Activities
___ Therapeutic Exercises	___Electrical Stimulation	___Spinal Manipulation
___ Therapeutic Ultrasound	___Cervical Traction	___Extremity Manipulation
___ Massage Therapy	___X-Rays	

Date of Service _________________________ Patient's Signature ____

___Office Visit	___Hot/Cold Pack	___Gait Training
___ Manual Therapy	___Whirlpool	___Functional Activities
___ Therapeutic Exercises	___Electrical Stimulation	___Spinal Manipulation
___ Therapeutic Ultrasound	___Cervical Traction	___Extremity Manipulation
___ Massage Therapy	___X-Rays	

Date of Service _________________________ Patient's Signature ____

Patient's signature on this document attests to the fact that the services set forth herein were actually rendered. The person rendering the medical services for which a claim will be submitted has explained the services to me in detail.

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

PATIENT: I, the undersigned patient, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance to Chapman Health Group for services and/or supplies rendered for treatment of personal injuries sustained in the incident of (Date) _____ to the undersigned patient and covered by Personal Injury Protection (P.I.P.) coverage or other insurance coverage under (patient) _____ in accordance with Florida Statutes 627.736(5), said treatment commencing on (Date of first treatment)_____. This assignment of benefits expressly revokes and replaces any previous assignment of benefits, direction to pay, or assignment of case of action I/we may have previously issued to Chapman Health Group for rights and benefits of insurance for services and for supplies rendered for treatment of personal injuries sustained in said incident of (Date)_____.The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P. or other insurance coverage. I have read the information herein and verify that it is true to the best of my knowledge and belief.

This assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received, and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payment of benefits to which I am due for treatment or supplies commencing on (Date of first treatment)_____. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statutes 627.736(6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the provider as Patient's assignee. I agree that Chapman Health Group may select any attorney it wishes, and understand and agree that the attorney selected may be different than the attorney handling my personal injury/bodily injury claim or case. Additionally, this assignment also grants to Chapman Health Group the right to request from and receive from (Insurance Carrier) _____ a current statement of insurance benefits paid, commonly referred to as a P.I.P./Med Pay log.

As part of this assignment of rights and benefits, which only becomes binding upon the insurance carrier upon their receipt of said assignment after its having been executed and dated by the health provider, I hereby instruct the insurance carrier that in the event the subject's medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by Chapman Health Group is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he may exercise their legal rights. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement containing any false, incomplete, or misleading information, he is guilty of a felony of the third degree. I have read the information herein and it is true to tbe best of my knowledge and belief.

_____ Date:_____

Patient Signature

_____

Print Patient Name

PROVIDER: The undersigned, on behalf of Chapman Health Group, hereby accepts assignment of the insurance rights and benefits for the services rendered to (patient)_____, with payments to be made directly to Chapman Health Group under (patient) _____'s Personal Injury Protection (P .I.P.), or other insurance coverage with (Insurance carrier) _____ and in accordance with Florida Statute 627.726 et. Seq. (5).

By: _____ Date: _____

E.I.N.#: _____

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_____