Fields CHIROPRACTIC REGISTRATION AND HISTORY

Patient Information

Date: _____

Last Name: _____

First Name: _____ M.I. ____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Email: _____

Would you like to receive billing notification via email? ☐ YES ☐ NO

Home: _____ Work: _____

Cell: _____ Other: _____

Birthdate: _____ Sex: ○Male ○Female

SSN: _____

Marital Status: ○Single ○Married ○Divorced ○Separated ○Partnered

Race:_____ Ethnicity:_____

Occupation: _____

Responsible Party

If you have insurance in someone else's name, please list that information here

Name: _____

Relationship: _____

SSN: _____

Birthdate: _____

Phone Number: _____

Insurance Assignment and Release

I certify that I, and/or my dependents have insurance coverage and assign directly to **Fields Chiropractic Clinics, P.A.** All insurance benefits are payable to this clinic for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that it is the policy holder's responsibility to verify coverage for services rendered. I authorize the use of my signature on all insurance submissions. Copayments, coinsurances, and deductible amounts are due at time services are rendered.

Fields Chiropractic Clinics, P.A. may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Patients **NOT** submitting insurance are responsible for payments of services rendered at the time of service.

_____

Signature of Patient/Guardian

_____

Printed Name

_____

Relationship to Patient

Accident Information

Is this visit related to a **RECENT** accident? ○Y / N○

Date of Accident: _____

Type of Accident: ○Auto ○Slip and Fall

Have you seen anyone else for this? ○Y /N○

If YES, please list:_____

PLEASE TURN OVER

Patient Condition

Chief complaint of pain? Neck Pain Mid Back Pain Low Back Pain R / L Arm Pain R / L Leg Headache Muscle Pain Other:_____

Have you had similar issues? Y / N **How long? _____ Have you seen anyone else for this condition?** Y / N **If Yes, whom? _____**

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain).

1 2 3 4 5 6 7 8 9 10

Nature of Pain Burning Cramping Dizziness Dull/Aching Numbness Sharp Shooting Stabbing Throbbing Tightness Tingling

How often do you have this pain? Constantly Frequently Occasionally Intermittently

Activities that alleviate pain: Chiropractic Care Heat Ice Massage Therapy Nothing Pain Medicine Rest Stretching Traction

Does the pain interfere with: Work Sleep Daily Routine Recreation Other:_____

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down Driving Lifting Reaching

FOR INJURIES RELATED TO A MOTOR VEHICLE ACCIDENT (please answer ALL questions)

Position in vehicle: Driver Passenger Rear Left Right Middle

Was the vehicle: Stopped Moving Turning Reversing In Traffic? Y / N

Where were you hit? Driver side Passenger side Front Rear

Were you wearing a seatbelt? Y / N

Airbags Deploy? Y / N

Hit Head? Y / N

Did you lose consciousness? Y / N

Did you have immediate pain? Y / N

Did you go to the Hospital? Y / N

If Yes, where? _____ When? _____

Transported by Ambulance? Y / N

Were X-Rays taken? Y / N

Please circle any of the following condition(s) that YOU have or have had:

AIDS/HIV	Bleeding Disorder	Fracture	High Blood Pressure	Osteoporosis	Rheumatoid Arthritis
Alcoholism	Breast Lump	Goiter	High Cholesterol	Pacemaker	Stroke
Allergies	Bulging Disc	Gout	Kidney Disease	Parkinson's Disease	Suicide Attempt
Anemia	Cancer	Heart Disease	Liver Disease	Pinched Nerve	Thyroid Problem
Angina	Diabetes	Hepatitis	Migraine Headache	Polio	Tuberculosis
Appendicitis	Eating Disorder	Hernia	Miscarriage	Prostate Problem	Tumors
Arthritis	Emphysema	Herniated Disc	Multiple Sclerosis	Prosthesis	Ulcers Asthma
Asthma	Epilepsy	Herpes	Neuropathy	Psychiatric Care	
Electronic Devices					

Habits: Smoking - packs/day_____ Alcohol Coffee/Caffeine

Occupation: _____

Work Activity: Sitting Standing Light labor Heavy labor

Pregnant: Y / N **Due Date:**_____

Injuries/Surgeries: In the last 5 years have you had any surgeries, fractures, motor vehicle collisions, falls, or any other major trauma?

_____

_____

_____

Have you ever had any spinal (neck, mid back, low back) surgeries?

_____

List all current medications:

_____

_____

_____

Family History

Is there a family history of any of the following condition(s)? If YES, please CIRCLE the relationship (M=mother, F=father, GM=grandmother, GF=grandfather)

Cancer: **M F GM GF** ***High Blood Pressure***: **M F GM GF** ***Diabetes:*** **M F GM GF** ***Depression:*** **M F GM GF**

Stroke: **M F GM GF** ***Alzheimer's Disease:*** **M F GM GF** ***Osteoporosis:*** **M F GM GF** ***Coronary Artery Disease:*** **M F GM GF**

Fields Chiropractic
3930 Devine Street ● Columbia SC ● 29205
Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-ray, on me (or the patient named below, for whom I am legally responsible for) by the doctor of chiropractic named above or licensed doctors of chiropractic at **Fields Chiropractic Clinic, P.A.**

I have had an opportunity to discuss with the doctor, or with office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a medical device upon my body to adjust a joint, which may cause an audible “pop” or “click”. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at any time to be in my best interest. Neither the practice of the chiropractor or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and the expertise in working with like cases.

I understand that as a part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party can verify that services billed were actually provided.

I have read or have had it read to me, the ***Informed Consent to Chiropractic Adjustments and Care.*** I have also had the opportunity to ask question about 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.

_____ _____

Name (Please Print) Date Signed

_____

Signature of Patient or Legal Guardian

Please Turn Over →

Notice of Privacy Practices Acknowledgment

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

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

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physicians certification.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by my restrictions.

_____ _____

Patient Name (Please Print) Relationship to Patient

_____ _____

Signature Date

Designated Party Release

You may give Fields Chiropractic Clinic written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, etc.) on your home answering machine, voice mail at work, cell phone, email, or another party that you designate.

Patient Name: _____ **Date of Birth:**_____

At my request, I authorize Fields Chiropractic Clinic to disclose my protected health information to:

For Motor Vehicle Accidents, please list your attorney's name and phone number

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

At my request, I also authorize Fields Chiropractic Clinic to communicate my protected health information to me via the following methods:

- ☐ Leave detailed message on my home answering machine (phone #:_____)
- ☐ Leave detailed message on my voice mail at work (phone #:_____)
- ☐ Leave detailed message on my cell phone voice mail (phone #_____)
- ☐ Fax detailed medical information (fax #_____)
- ☐ E-mail detailed medical information (email:_____)

Authorized Signature: _____ Date:_____

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____