CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

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 directly to
Name of Insurance Company(ies)

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

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 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 Comp. ☐ Other

Attorney Name (if applicable) _____

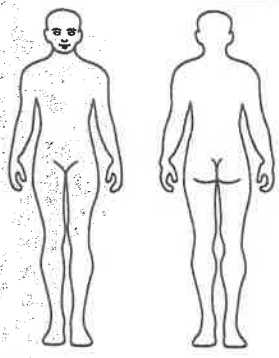
5 PATIENT CONDITION

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

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

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

SNYDER CHIROPRACTIC DR. SCOTT B. SNYDER
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Electronic Health Records Intake Form

In compliance with requirements for the government HER incentive program

First Name:_____ Last Name:_____

Email Address:_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ____/____/_____ Gender (Circle one): Male / Female Preferred Language:_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

What year did you begin smoking?_____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native/Asian/Black or African American/White (Caucasian)/ Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please included regularly used over the counter medications)

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

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature:_____ Date:_____

For Office Use Only

Height:_____ **Weight:**_____ **Blood Pressure:** _____ / _____ **Pulse:**_____

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OFFICE POLICY

INTIAL VISIT: A complete chiropractic examination will be performed prior to any treatment. X-rays may be necessary in order to rule out possible bone and joint diseases and to locate spinal misalignments. If you have recently had X-rays of your current problem, please inform us as they may aid in our diagnosis and thus eliminate the need for additional X-rays at this time.

INSURANCE COVERAGE: It is our policy to bill your insurance carrier as a courtesy to you. However, your bill is always your responsibility because insurance is an agreement between you and your insurance carrier.

MAJOR MEDICAL: You are expected to pay in full for services rendered today. You acknowledge you are responsible for all insurance co-pays and deductible amounts owed by you.

WORKERS COMPENSATION: Written consent/authorization must be provided to our office from your workers compensation adjuster in order to receive treatment in our office.

AUTO ACCIDENTS: I herby instruct and direct my auto insurance company to pay by check or draft directly to the above listed provider. Auto insurance pays 80-100% for your care in order to qualify for this care you need to provide us with your claim number, and we will file medical claims on your behalf.

MEDICARE: Medicare allows an unlimited amount of chiropractic visits per year. You are responsible for your calendar year deductible. X-rays are required at a cost of $50.00, but not paid for by Medicare.

CASH PATIENTS: If you don't have insurance all fees are payable when services are rendered unless prior arrangements have been made.

CANCELLED APPOINTMENTS: Chiropractic appoints require 24 hour advance notice and **MASSAGE** appointments require 48 hour advance notice to avoid a $25.00 cancelation fee. This fee will be placed on your account and is 100% your responsibility.

_____ _____

Patient Signature Date

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INFORMED CONSENT

It is important to acknowledge the difference between health care and the specialty of Chiropractic care. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of Chiropractic procedures often depends on the environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

A patient, in coming to the Doctor of Chiropractic, gives the Doctor Permission and authority to care for the patient in accordance with Chiropractic tests, diagnosis and analysis. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying psychical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a chiropractic adjustment or treatment if he is aware that such care may be contracted. It is the sole responsibility of the patient to make it known to the doctor of any health care procedures that you have had as well as any defect, illness, or deformity you may be suffering from.

The purpose of Chiropractic Care is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the Chiropractic procedures as each individual person/case is unique to that patient. In most cases there is a more gradual, but a quite satisfactory response. Occasionally, the results are less than expected. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped my medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

Please discuss any questions or medical problems with the doctor prior to treatment.

I have read and understand the forgoing consent to treatment.

_____ _____

Patient Signature Date

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HIPAA

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read the Notice of Privacy Practices.

Patient Name:_____

Date of Birth:_____

Signature:_____

Date:_____

Who may we speak with on your behalf:_____

_____

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Insurance Assignment of Benefits and Instruction for Direct Payment

I, _____, herby instruct and direct my insurance company pursuant to F.S.627.422 to pay by check or draft made out to and mailed directly to the above-named provider for professional or medical services. And any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment is to not exceed my indebtedness to the above-named provider.

I herby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, Personal Injury Protection (PIP), IP, Disability, or any other Health or Medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above-named provider.

If my current policy prohibits direct payment to the doctor, then I herby instruct and direct you to make out the check payable to me and mail it to the office indicated above.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above-named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I also agree that the above-mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for services in full at the time services are rendered. Ultimately, payment responsibility rests with you the patient.

I also authorize the release of any information pertinent to my case or claim to the above-named provider or any attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

I herby authorize the above-named provider to file any informal complaints that are necessary to the Insurance Commissioner's Office or agency or court they deem appropriate on my behalf.

_____	_____	_____
Signature of Patient (Claimant)	Print Name	Date
_____	_____	_____
Witness (If Minor)	Print Name	Date