Stubbendieck Chiropractic & Rehabilitation Registration and History

Patient Information **(Social Security#:_____)** **Patient HR#:_____**

LastName_____FirstName_____

Address_____ City/State/Zip _____

Home Phone (#)_____Email_____Driver's License #_____

Cell Phone (#) _____ Cell Phone Provider_____

Sex [] M [] F Age_____ Birth date_____[ ] Married [ ] Widowed [ ] Single [ ] Divorced

Employer_____Occupation_____

Spouses Name_____ DOB_____ Spouses Employer_____

Primary Care Physician?_____ Address/Phone_____

Permission to send Health information to this Provider? Y/N

Whom may we thank for referring you to this office?_____

Insurance Assignment and Release ***(Must provide copy of Insurance Card and Photo ID;** Copies provided_____)

Primary Insurance_____ Secondary Insurance_____

I certify that I, and/or my dependent(s), have coverage with the Insurance company listed above and assign directly to Stubbendieck Chiropractic, 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. The above-named entity may share my health information with the above-named Insurance Company(ies) for the purpose of obtaining payment and determining benefits for related services. X_____

As a courtesy, we will verify your benefits. We highly encourage you to double-check your benefits as we are often misquoted by customer service representatives. X_____

Person to contact in case of emergency:
Name:_____
Phone:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Stubbendieck Chiropractic, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature_____ Date_____

Health History

Is the condition due to an accident? [ ]Yes* [ ]No Date:_____ **Type?** [ ]Auto [ ]Work [ ]Home [ ]Other
(*If yes, must complete PI or Work Comp Forms)

To whom have you made a report? [ ]Auto Insurance [ ]Employer [ ]Workers Comp [ ]Other
Claim Number _____ **Insurance Phone Number**_____ **Attorney Name**_____

Have you received any of the following treatments for your condition?

[ ] Medication [ ] Surgery [ ]Physical Therapy [ ] Chiropractic [ ] None [ ]Other:_____

Name and Address of other doctor(s) who have treated 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 _____

Please Circle to indicate if you have had any of the following:

AIDS/HIV	Appendicitis	Arthritis	Asthma	Bleeding Disorders
Bronchitis	Cancer	Diabetes	Emphysema	Epilepsy
Fractures	Gout	Heart Disease / (HBP)	Hepatitis	Hernia
Herniated Disc	Herpes	High Cholesterol	Kidney Disease	Liver Disease
Migraines	Miscarriage	Multiple Sclerosis	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Pneumonia	Polio	Prosthesis
Psychiatric Care	Rheumatoid Arthritis	Stroke	Thyroid Problems	Tonsillitis
Tuberculosis	Tumors, Growths	Typhoid Fever	Ulcers	Metal, Mechanical, Electrical Implants
Other (write in):				

Family History please check all that apply: □Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke
□ Rheumatoid Arthritis □ Other_____

Social History please check all that apply:

Exercise
[ ]None[ ]Moderate
[ ]Light [ ]Heavy
[ ]Coffee/Caffeine Cups/Day_____

Work Activity
[ ]Sitting [ ]Standing
[ ]Light Labor [ ]Heavy Labor

Habits
[ ]Smoking Packs/Day_____
[ ]Alcohol Drinks/Week_____

Are you pregnant? [ ]Yes [ ]No **Due Date: _____Any Challenges with Pregnancy?_____**
Head Injuries _____
Broken Bones/Dislocations _____
Illness/Disease _____
Surgeries (include year) _____ **Other**
Please list any/all that apply below or provide a list:

Medications	Allergies	Vitamins/Herbs/Minerals

Patient Name: _____ Date:_____HR#: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary:_____Secondary: _____

Third: _____Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____

When is the problem at its worst?(check) __AM ___PM ___Mid-day ___Late PM

How long does it last? _____It is constant_____ (OR) I experience it on and off during the day_____

(OR) It comes and goes throughout the week_____

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? _____No _____*Yes (*If yes,) When: _____ (date)

Type of Treatment _____

How long were you under care: _____ What were the results_____

Have you ever been under Chiropractic Care? Y N If Yes, Name of Dr._____

When/Purpose/Results?_____

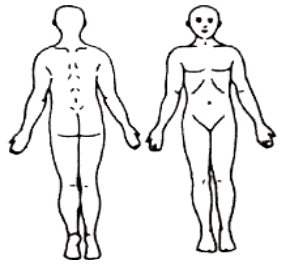
What relieves your symptoms? _____

What makes your symptoms feel worse_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms**:**

R = Radiating **B =** Burning **D =** Dull **A =** Aching **N =** Numbness **S =** Sharp/Stabbing **T =** Tingling

Describe your symptoms/onset/injury:_____



_____

_____

_____

_____

_____

_____

LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Additional Restrictions:_____

_____

_____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

Patient Name: _____ Date:_____HR#: _____

Stubbendieck Chiropractic and Rehabilitation Centers
257 S. Court St., Suite 5-A, Medina, OH 44256 Phone: (330) 725-4060 Fax: (330) 722-4582
197 N. Pardee St., Wadsworth, OH 44281 Phone: (330) 334-1641

Patient Name: _____ Date:_____HR#: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Stubbendieck Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

**Women Only:*

*To the best of my knowledge (I **am / am NOT)** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation. (*Circle one above*) (*Circle one above*)

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit. Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $30 - $60

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?
Spouse: _____
Children: _____
Others: _____
No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____