

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____
Street City State Zip

PHONE NUMBERS Home _____ Work _____

E-Mail(s) _____

Sex: M F Age _____ Birthdate _____

Single Married Civil Union Widowed Separated Divorced

Patient SS# _____ Occupation _____

Employer _____ Employer Address _____

Employer Phone _____

Spouse's Name _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

What treatment have you already received for your condition? Medication Surgery Physical Therapy

Name and address of other doctor(s) who have treated you for your condition. _____

Whom may we thank for referring you? _____

HEALTH HISTORY

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

EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Water <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Pack/Day _____ Drinks/Week _____ Glasses/Day _____ Cups/Day _____ Reason _____

Are you pregnant? Yes No Due Date _____ Number of Children _____

Injuries/Suggeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Primary Care Physician _____ May we contact them? yes no

OFFICE POLICY

Office Payment Policy

Payment is expected at the time services are rendered whether you are covered by insurance or not. We do accept Mastercard and Visa. Our office will submit bills to your insurance carrier, however please be advised that if a service is not covered, payment is denied or significantly delayed, you are responsible for payment in full. If you are experiencing financial difficulties, we ask that you contact us promptly so that a payment plan can be established.

If you are claiming Worker's Compensation, you must provide us with a first report of injury from your employer at your initial visit. If this information is not provided, you will be responsible for payment in full for your services until one is received and your claim is verified.

If you are claiming an Auto Accident, you must provide us with your personal automobile insurance information at your initial visit. If this information is not provided, you will be responsible for payment in full for your services until it is received and your claim is verified.

Cancellation Policy

If you are unable to make a scheduled appointment, our office requires you to contact us at least 24 hours in advance. Our office does reserve the right to charge you for any missed appointment. If you have health, auto or workers compensation coverage, your insurance will not be billed for the visit. Payment for this time is due in full from you prior to your next appointment

Permission Statement

I hereby give permission for Drs. Jim and Julia McDaniel to examine me as he/she deems necessary through the use of chiropractic health care, and I give authority for these procedures to be performed.

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Drs. Jim and Julia McDaniel 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 hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date



McDaniel Chiropractic Center

Experience The Benefits

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION AT MCDANIEL CHIROPRACTIC CENTER

Our Privacy Pledge:

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and will always, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- *We may have to disclose your health information to another health care provider or a Hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- *We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- *We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in this notice. If we make a change to our privacy practices, we will notify you in writing when you come in for a treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the aforementioned use of disclose of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restrictions are binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name

Date

Signature

Authorized Provider Representative

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of McDaniel Chiropractic Center's Notice of Privacy Practices for Protected Health Information.

Patient Name Printed

Date

Patient Signature

Authorized Provider Rep.

Personal Representative Printed

Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient

Dr. James McDaniel

Dr. Julia McDaniel

**AUTHORIZATION FOR PRIVATE PATIENT INFORMATION
DISCLOSURE**

I, _____, hereby authorize McDaniel Center to share information regarding my treatment, appointments and office finances with:

Name _____ Relationship _____

Name _____ Relationship _____

I expressly acknowledge that this authorization is voluntary and may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

Patient Name Printed

Patient Signature

Date