Ark Valley Chiropractic

Chiropractic Registration and History

Patient Information

Date __________________ SSN _____________________

Patient Name ____________________________________

Address ____

____

City_______________________St______Zip___________

E-Mail ____

Sex [ ] M [ ] F Age _______ Birthdate ____________

[ ] Married [ ] Widowed [ ] Single [ ] Child

[ ] Separated [ ] Divorced [ ] Partnered for ___ years

Employer/School _________________________________

Occupation ______________________________________

Employer Phone __________________________________

Spouse's Name ___________________________________

Spouse's Birthdate _______________________________

Spouse's Employer _______________________________

Names and ages of Children _______________________

____

____

How did you hear about this office? _______________

Phone Numbers

Cell # (___)____________ Home # (___)____________

In case of emergency, please contact

Name ___________________ Relationship ___________

Cell # (___)____________ Home # (___)____________

Insurance Information

Who is responsible for this account? _______________

Policy Holder's Birthdate __________________________

Insurance Company ________________________________

ID Number ______________________________________

Group Number ___________________________________

Insurance Company Phone ________________________

Is patient covered by additional insurance? [ ] Y [ ] N

Insurance Company ________________________________

ID Number ______________________________________

Group Number ___________________________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Ark Valley 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. I authorize the use of my signature on all insurance submissions.

Ark Valley Chiropractic 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.

I also agree to permit electronic communication, including but not limited to cellular devices and email, concerning any and all aspects of my account.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Print name of Patient, Parent, Guardian or Personal Representative

____________________ ________________________

Date Relationship to Patient

Medicare Disclaimer

Medicare DOES cover Chiropractic manipulations, with the limitation of manipulations to the spine. Treatment must be determined to be medically necessary. **Medicare does not cover** therapies, supports, nutrition, examinations, x-rays, laboratory studies or maintenance therapy. **Medicare REQUIRES** that a treatment plan be **established and followed**, with the expected results of some functional improvement from sublaxations thus, re-establishing a degree of spinal health. **Medicare will not pay for anything, which it considers to be maintenance** therapy. By my signature I understand and accept this policy, also understanding that I am personally responsible for payment of any procedure, which Medicare determines not, payable under Medicare Part B, and I agree to pay promptly. I further understand that I am liable for my annual deductible and any changes, which are not paid by Medicare or my secondary insurance company.

I understand that it is required for me to have an examination to determine the subluxations, and I understand Medicare does NOT cover this exam and I am responsible to pay for the examination at the time of service.

____ ____________________

Signature Date

Accident Information

Is your condition due to an accident? [ ] Yes [ ] No Date of Accident ______________________________

Type of accident [ ] Automobile [ ] Work [ ] Home [ ] Other ____________________________________

To whom have you made a report of your accident? [ ] Auto Insurance [ ] Employer [ ] Worker Comp [ ] Other

Attorney name (if applicable) ______________________________

Auto Insurance Company ___________________________ Auto Claim Number ____________________________

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 yes or no to indicate if you have had any of the following:

AIDS/ HIV Yes No
Alcoholism Yes No
Allergy Shots Yes No
Anemia Yes No
Anorexia Yes No
Appendicitis Yes No
Arthritis Yes No
Asthma Yes No
Bleeding Disorders Yes No
Breast Lump Yes No
Bronchitis Yes No
Bulimia Yes No
Cancer Yes No
Cataracts Yes No
Chemical Dependency Yes No
Chicken Pox Yes No
Diabetes Yes No

Depression Yes No
Emphysema Yes No
Epilepsy Yes No
Fractures Yes No
Glaucoma Yes No
Goiter Yes No
Gonorrhea Yes No
Gout Yes No
Heart Disease Yes No
Hepatitis Yes No
Hernia Yes No
Herniated Disk Yes No
Herpes Yes No
High Blood Pressure Yes No
High Cholesterol Yes No
Kidney Disease Yes No
Liver Disease Yes No

Measles Yes No
Migraines Yes No
Miscarriage Yes No
Mononucleosis Yes No
Multiple Sclerosis Yes No
Mumps Yes No
Osteoporosis Yes No
Pacemaker Yes No
Parkinson's Disease Yes No
Pinched Nerve Yes No
Pneumonia Yes No
Polio Yes No
Prostate Problem Yes No
Prosthesis Yes No
Psychiatric Care Yes No
Rheumatoid Arthritis Yes No
Rheumatic Fever Yes No

Scarlet Fever Yes No
Spina Bifida Yes No
STD Yes No
Stroke Yes No
Suicide Attempt Yes No
Thyroid Problems Yes No
Tonsillitis Yes No
Tuberculosis Yes No
Tumors, Growths Yes No
Typhoid Fever Yes No
Ulcers Yes No
Vaginal Infections Yes No
Whooping Cough Yes No
Other ________
____
____
____

Exercise	Work Activity		Social Habits	
[ ] None	[ ] Sedentary	[ ] Light Labor	[ ] Smoking	Packs/Day
[ ] Moderate	[ ] Sitting	[ ] Heavy Labor	[ ] Alcohol	Drinks/Week
[ ] Daily	[ ] Standing	[ ] Repetitive	[ ] Coffee/Caffeine Drinks	Cups/Day
[ ] Heavy	[ ] Walking	[ ] Computer	[ ] High Stress Level	Reason
			[ ] Recreational Drug Use	

Are you pregnant? [ ] Yes [ ] No Due Date ____

Please provide the following information of your grandparents, parents or siblings (mark with G,P or S)

Have any of the above listed family members had the following?

_____ Allergies / Asthma / Crohns
_____ Mental Illness / Social Dysfunctions
_____ Cerebral Vascular Stroke
_____ Thyroid Disease
_____ Respiratory Disease / Emphysema
_____ Heart Disease / Murmurs
_____ Digestive Diseases / Ulcers / IBS

_____ Arthritis / Scoliosis / Spina Bifida
_____ Liver / Gall Bladder Disease
_____ Diabetes
_____ Kidney / Urinary Tract Dysfunctions
_____ High Blood Pressure
_____ Cancer / AIDS / HIV
_____ Multiple Sclerosis / ALS

Injuries/Surgeries you've had		Date
Falls		____________________
Head Injuries		____________________
Broken Bones		____________________
Dislocations		____________________
Surgeries		____________________

Medications	Vitamins/Herbs/ Minerals	Allergies
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________