VALLEY OPTIMAL SPINE

80 Broadway Suite 1A, Cresskill, NJ, 07626
(T) 201-569-1212

PATIENT REGISTRATION

Section 1: Patient Information

PATIENT NAME		DOB	SEX M/F	MARITAL STATUS Single/Married/Other
SSN *(optional)*	HOME TEL	MOBILE	E-MAIL	

Text Message Appointment Reminder? Yes/No If yes, please check off your mobile provider:

€ AT&T € Boost € Cricket € MetroPCS € Sprint € T-Mobile € US Cellular € Verizon € Virgin Mobile € Other:

STREET	CITY	STATE	ZIP

EMPLOYMENT STATUS ☐Employed ☐Student (part) ☐Student (full) ☐Retired ☐Unemployed ☐Homemaker

EMPLOYER	SCHOOL

Section 2: Insurance Information

Primary Health Insurance

INSURANCE COMPANY		INSURANCE TEL	
MEMBER ID	INSURED'S NAME	INSURED'S DOB	RELATION TO INSURED
INSURED'S EMPLOYER	EMPLOYER'S ADDRESS		

Secondary Health Insurance

INSURANCE COMPANY		INSURANCE TEL	
MEMBER ID	INSURED'S NAME	INSURED'S DOB	RELATION TO INSURED
INSURED'S EMPLOYER	EMPLOYER'S ADDRESS		

Automobile Insurance *(automobile accident only)*

INSURANCE COMPANY			INSURANCE TEL
POLICY NO.	POLICY HOLDER'S NAME	ACCIDENT DATE	CLAIM NO.
ADJUSTER'S NAME	ADJUSTER'S TEL		

Referral Information

HOW DID YOU HEAR ABOUT US?

☐Another patient ☐Physician office ☐Newspaper ☐Yellow Pages ☐LA Fitness ☐Walk-in ☐Other

NAME OF PERSON REFERRING YOU TO OUR OFFICE

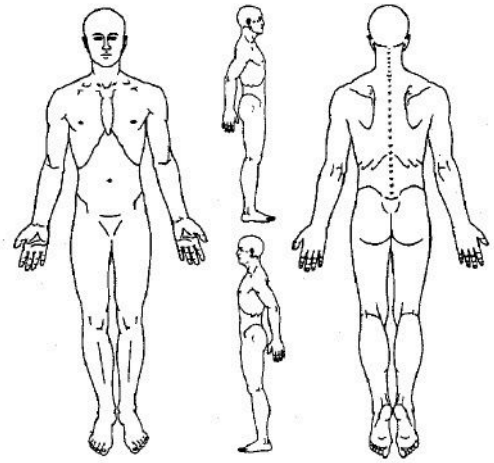
Section 3: Current Complaints

WHERE DO YOU HAVE PAIN?

IS PAIN DUE TO AN ACCIDENT? *(if yes, complete Section 4)* YES/NO	PAIN STARTED ON	UNABLE TO WORK? YES/NO	UNABLE TO WORK FROM-TO (DATE)

HOW DID THIS PAIN START

MARK WHERE YOU HAVE PAIN



TYPE OF PAIN ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Radiating ☐Other:

PAIN FREQUENCY ☐Constant *(76-100%)* ☐Frequent *(51-75%)* ☐Intermittent *(25-50%)* ☐Occasional *(0-25%)*

PAIN WORSENED ☐Sitting ☐Standing ☐Walking ☐Running ☐Bending ☐Lying down ☐Lifting ☐Driving ☐Other:

PAIN RELIEVED BY

PAIN INTERFERES ☐Work ☐Sleep ☐Recreation ☐Daily Routine

PAIN SCALE

0=no pain
1-3=mild pain
4-6=moderate pain
7-8=severe pain
9-10=extreme pain

NECK 0 1 2 3 4 5 6 7 8 9 10	SHOULDER/ARM 0 1 2 3 4 5 6 7 8 9 10
MID BACK 0 1 2 3 4 5 6 7 8 9 10	LOW BACK 0 1 2 3 4 5 6 7 8 9 10
HIP/LEG 0 1 2 3 4 5 6 7 8 9 10	FOOT/ANKLE 0 1 2 3 4 5 6 7 8 9 10
HEADACHE 0 1 2 3 4 5 6 7 8 9 10	OTHER: 0 1 2 3 4 5 6 7 8 9 10

Section 4: Accident History

ACCIDENT DATE	ACCIDENT TYPE ☐Automobile ☐Bus ☐Motorcycle ☐Bicycle ☐Pedestrian ☐Slip and fall	WORK RELATED ACCIDENT YES/NO

YOU WERE SEATED ☐Driver's ☐Front passenger ☐Back passenger	SEAT BELT YES/NO	AIR BAGS DEPLOYED YES/NO

VEHICLE DAMAGE Mild/Moderate/Severe/Total loss	WHERE ACCIDENT OCCURRED

HOW ACCIDENT OCCURRED

UPON IMPACT, YOUR BODY ☐Tensed ☐Whipped front-back ☐Whipped side-side ☐Twisted ☐Hit against:

IMMEDIATELY AFTER THE IMPACT, YOU EXPERIENCED ☐Unconsciousness ☐Nausea ☐Dizziness ☐Weakness ☐Other: ☐Pain in:

WERE YOU TAKEN TO HOSPITAL YES/NO	VISIT DATE	HOSPITAL NAME

STUDIES DONE AT HOSPITAL ☐X-RAY ☐MRI ☐CT SCAN ☐OTHER:
(specify studied regions)

OTHER PHYSICIANS YOU SAW SINCE ACCIDENT (NAME)	PHYSICIAN TEL	VISIT DATE

ATTORNEY NAME	FIRM	ATTORNEY TEL

Section 5: Medical History

PRIMARY PHYSICIAN NAME	PHYSICIAN TEL

CHECK ALL THAT APPLIES TO YOUR MEDICAL HISTORY

☐AIDS/HIV+	☐Diabetes	☐Infectious Mono	☐Scarlet fever
☐Anemia	☐Diphtheria	☐Kidney disease	☐Shingles
☐Arthritis	☐Epilepsy	☐Liver disease	☐Smallpox
☐Back pain	☐Glaucoma	☐Measles	☐Stroke
☐Bladder infection	☐Heart disease	☐Migraine	☐Thyroid disease
☐Bleeding tendency	☐Hemorrhoids	☐Mitral valve prolapse	☐Tuberculosis
☐Blood/plasma transfusions	☐Hepatitis	☐Mumps	☐Ulcer
☐Bronchitis	☐Hernia	☐Rheumatic fever	☐Venereal disease
☐Cancer	☐High/low blood pressure	☐Pneumonia	☐Whooping cough
☐Chickenpox	☐Hives/eczema	☐Polio	☐Other:

DESCRIBE ANY CURRENT OR PAST MEDICAL CONDITION NOT LISTED ABOVE

PAST SURGERIES

CURRENT MEDICATIONS

PAST ACCIDENTS/INJURIES

Section 6: Social History

SMOKE OR TOBACCO PRODUCTS YES/NO	IF YES, HOW MUCH PER DAY	IF NO, HAVE YOU IN THE PAST YES/NO
ALCOHOLS YES/NO	IF YES, HOW MUCH PER WEEK	IF NO, HAVE YOU IN THE PAST YES/NO
COFFEE OR TEA YES/NO	IF YES, HOW MUCH PER DAY	IF NO, HAVE YOU IN THE PAST YES/NO
EXERCISE YES/NO	IF YES, HOW MANY DAYS PER WEEK	

Section 7: Patient Signature

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

PATIENT SIGNATURE	DATE

Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, x-ray, digital imaging, therapeutic ultrasound, dry hydrotherapy, axial traction, extension compression traction, rehabilitation, exercising and stretching, inter-segmental traction, flexion-distraction traction, therapy ball, massage therapy, soft tissue therapy, various topical pain relief creams and/or lotions, may also be used in conjunction with your treatment.

Possible risks: I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. As with any health care procedure, complications are possible following a chiropractic manipulation. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Complications, while extremely rare, could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications such as Vioxx have been shown to cause heart damage & death.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence / addiction in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Many patients treated in a hospital leave with conditions worse than their original complaint.
- *Surgery* in conjunction with medical care adds the risks of infection and adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Surgery can result in permanent loss of function or death.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. Patients who do not follow their approved chiropractic treatment plan may revert to their original symptoms, or even become worse from failing to finish treatment.

For WOMEN: X-RAY RISKS

Are you pregnant or any chance you may be: _____ YES _____ NO

X-ray uses radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. If you feel that you may be pregnant, please inform the chiropractor before your exam.

_____ To the best of my knowledge I am not pregnant or believe there is any possibility that I may be pregnant.
_____ I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction.

Signature of Patient or Personal Representative Date

Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Patient Name: **Date of Birth:**

Address: **City:** **State:** **Zip:**

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS TO OUR NOTICE, AT ANY TIME BY CONTACTING:

Valley Optimal Spine
80 Broadway Suite 1A Cresskill, N.J. 07626
(T)201-569-1212/(F)201-569-4494
drfrankca@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: **Date:**

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, PLEASE COMPLETE THE FOLLOWING:

Personal Representative's Name:

Relationship to Patient: