PURELIFE PATIENT REGISTRATION FORM

PATIENT INFORMATION Date:

Name _____ Social Security No. _____

Street Address _____

City, State, Zip _____

Phone Numbers Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Biological Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation _____ Employer _____

Employer's Address _____

Employer's Phone _____

In case of emergency, contact _____

Relationship _____ Phone _____

Whom may we thank for referring you to PureLife Chiropractic?

_____

Best way to remind you of next appointment: ☐ Phone _____ ☐ E-mail _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship _____

Insurance Co. _____ ID/Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insured's Name _____ Relationship _____

Insured's Birthdate _____ SS# _____

Insurance Co. _____ Group # _____

PATIENT CONDITION

Reason for this visit _____

When did symptoms appear? _____

Is condition getting progressively worse? ☐ Yes ☐ No

Have you seen another doctor for this condition? ☐ Yes ☐ No If Yes, whom? _____

Is this injury related to an accident? ☐ Yes ☐ No ☐ Car Accident ☐ Work Related

☐ Slip/Fall ☐ Other _____

To whom have you reported this injury? ☐ Auto Insurance ☐ Employer

☐ Workers' Comp ☐ Other _____

Attorney name, if applicable _____

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No

If Yes, please describe _____

I hereby authorize my insurance company benefits to be paid directly to PureLife Chiropractic I realize I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent information to the insurance company.

Patient or Legal Representative Signature _____ Date _____

PURELIFE CHIROPRACTIC

Patient Confidential Health History

Patient Name _____ Date _____

SYMPTOMS Please check any of these symptoms you have experienced in the last 6 months.

General
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weight Loss or Gain
- ☐ Rashes

Ear, Eye, Nose, Throat
- ☐ Poor/Blurred Vision
- ☐ Pain in eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Nosebleeds
- ☐ Hoarseness

Gastrointestinal
- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Difficulty Swallowing
- ☐ Belching or Gas
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Pain Over Abdomen
- ☐ Black or Bloody Stool
- ☐ Jaundice
- ☐ Diarrhea
- ☐ Constipation

Respiratory
- ☐ Difficulty In Breathing
- ☐ Chronic Cough/Bronchitis
- ☐ Productive Cough

Cardiovascular
- ☐ Ankle Swelling
- ☐ Chest Tightness/Pain

Genitourinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Inability to Control Urination
- ☐ Difficulty Starting Urine Flow
- ☐ Get Up at Night to Urinate

Musculoskeletal
- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Muscle Aches/Soreness

Skin
- ☐ Itching
- ☐ Bruising Easily
- ☐ Change in Mole(s)

Neurologic
- ☐ Weakness
- ☐ Tremors
- ☐ Dizziness
- ☐ Numbing/Tingling
- ☐ Arm/Leg Pain

Women Only
- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Irregular Cycles
- ☐ Vaginal Burning/Itching
- ☐ Hot Flashes
- ☐ Breast Lump
- ☐ Date Last Period Began
- ☐ Date of Last Pap Smear

Men Only
- ☐ Testicular Swelling/Pain
- ☐ Breast Lump

FAMILY HISTORY (Do not include yourself (Include information on brothers, sisters, parents, grandparents)
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Thyroid Disease/Goiter
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Seizures/Strokes
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Ulcers
- ☐ Muscle, Bone or Nerve Disease

Miscellaneous _____

☐ Adopted/Family History Unkown

DIAGNOSIS - Please check if you have ever been diagnosed with any of the following

General
- ☐ Allergies
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid Disease/Goiter
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Anorexia/Bulemia
- ☐ Chicken Pox

Ear, Eye, Nose, Throat
- ☐ Sinus Infection
- ☐ TMJ
- ☐ Cataracts
- ☐ Glaucoma

Musculoskeletal
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Arthritis

Gastrointestinal
- ☐ Ulcer
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Appendicitis

Respiratory
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema

Cardiovascular
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Heart Attack/Heart Disease
- ☐ High Cholesterol

Genitourinary
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ STD
- ☐ AIDS,HIV,Hepatitis

Neurologic
- ☐ Headache/Migraine
- ☐ Epilepsy/Seizures
- ☐ Depression/Anxiety Disorders
- ☐ Multiple Sclerosis

Women Only
- ☐ Miscarriage

Skin
- ☐ Skin Cancer

Men Only
- ☐ Prostate Problems

PURELIFE CHIROPRACTIC

Patient Name _____

Patient Confidential Health History

Date _____

LIFESTYLE

Exercise
- ☐ None
- ☐ 1-2 Times/Week
- ☐ 3-5 Times/Week
- ☐ 6-7 Times/Week

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ N/A

Habits
- ☐ Smoking - Packs/Day ____
- ☐ Alcohol - Drinks/Week ____
- ☐ Coffee/Caffeine Drinks - Cups/Day ____
- ☐ High Stress Level
  Reason _____
- ☐ Recreational Drug Use _____

INJURIES/SURGERIES YOU HAVE HAD

	Description	Date
Auto Accident		
Falls/Major Injuries		
Broken Bones/Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

PURELIFE CHIROPRACTIC

PAYMENT AND INSURANCE Initials _____

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT TO TREATMENT OF A MINOR CHILD Initials _____

I authorize PureLife Chiropractic to administer chiropractic case as deemed necessary to my _____ (relationship), _____ (name).

FEMALE PATIENTS Initials _____

This is to certify that to the best of my knowledge I am NOT pregnant and that PureLife Chiropractic has my permission to order X-rays.
Beginning date of your last menstrual period _____.

CONSENT TO CHIROPRACTIC SERVICES Initials _____

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays and or tests by PureLife Chiropractic and their staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor named above and/or with other personnel of PureLife Chiropractic the nature and purpose of treatment indicated.

I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signed _____ Date _____

Witness _____ Date _____

PureLife Chiropractic, PLLC: HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **Get an electronic or paper copy of your medical record**: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications: You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you: If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html**. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care or payment for your care, share information in a disaster relief situation, include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again. If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety. **Do research:** We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:
For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice was published and becomes effective on/before February 16, 2026.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or via phone at (423)434-2080.

By signing below, you acknowledge that you have read and understand all of the provided HIPAA information.

Print Name: _____ Signature: _____ Date: _____