This is an interactive form. You may fill it in before you print.

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** _____ **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. _____ **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** _____

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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
- ☐ Fatigure
- ☐ Weight Loss or Gain
- ☐ Rashes

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

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 _____

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

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

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PURELIFE CHIROPRACTIC

Patient Confidential Health History

Patient Name _____ **Date** _____

LIFESTYLE

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

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

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

Reason _____

INJURIES/SURGERIES YOU HAVE HAD

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

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

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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 _____

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HIPAA NOTICE OF PRIVACY PRACTICES

PureLife Chiropractic
217 E Springbrook, Suite #1
Johnson City, TN 37601
(423) 434-2080

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

This is an interactive form. You may fill it in before you print.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will be not restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (423) 434-2080.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____

This form is not sent over a secure server so we do not recommend you e-mail it but if you prefer you may click the button below to send it.

Click to E-mail