Norton Chiropractic Center New Patient/Practice Member Registration

3725 S. Cleveland-Massillon Rd. #8 – Norton, Ohio 44203
Office: 330-825-5502 Fax: 330-825-9446

PATIENT INFORMATION

First Name: _____

Last Name: _____

Nickname: _____

Address 1: _____

Address 2: _____

City: _____ State: ____

Zip code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Social Security Number: ____--____--____

Driver's License #: _____

☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____

☐ Single ☐ Married ☐ Separated

☐ Widowed ☐ Other _____

Spouse/Significant other's name: _____

# of Children AT Home _____ # OUT of Home _____

INSURANCE INFORMATION

Policy Holder Name: _____

Relation to Patient: _____

Insurance Company: _____

ID #: _____ Group #: _____

Policy Holder Birthdate: _____/_____/_____

Policy Holder SS#: ____--____--____

Secondary Insurance? ☐ Yes ☐ No

2nd Insurance Company Name: _____

ID #: _____ Group #: _____

OTHER INFORMATION

Emergency Contact: _____

Relationship: _____

Phone: Home _____ Work _____

REFERRED BY: _____

Family Physician: _____

Address: _____

Phone: _____

May we contact them regarding your health? Y / N

Occupation: _____ Employer: _____

Address: _____ Phone: _____

☐ FT ☐ PT ☐ Student ☐ Unemployed ☐ Other: _____

What are your expectations from Dr. Murphy as Your (or Your Entire Family) Chiropractor??

☐ Short Term Care- Pain Relief/Bandage Care ☐ Pain Relief, Corrective Care, Restoration of Health

☐ Pain Relief, Corrective Care, Restoration of Health, and Continued WELLNESS CARE

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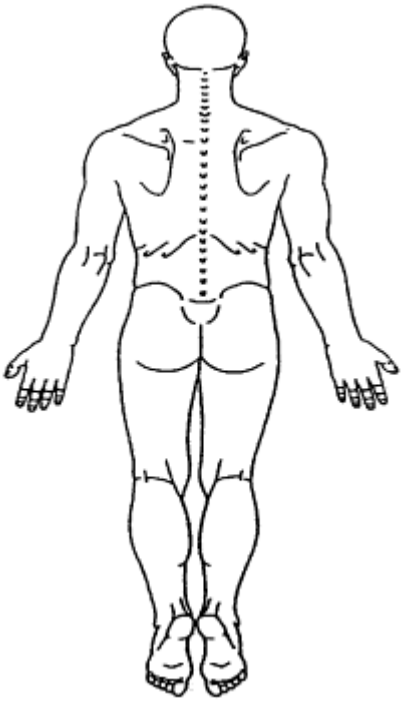
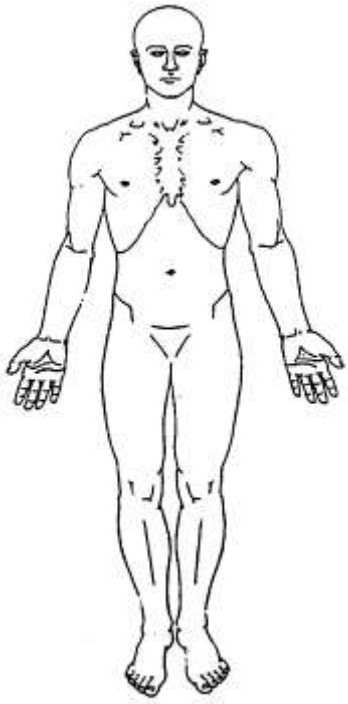
NAME: _____ **DATE**:_____

PLEASE CHECK AREA(S) OF CONCERN:

CONDITION	CONSTANTLY/ FREQUENTLY	SOMETIMES/ OCCASIONALLY
HEADACHE	☐	☐
MIGRAINE	☐	☐
NECK PAIN L/R/BOTH	☐	☐
SHOULDER PAIN L/R/BOTH	☐	☐
ARM/HAND PAIN L/R/BOTH	☐	☐
MID BACK PAIN L/R/BOTH	☐	☐
LOW BACK PAIN L/R/BOTH	☐	☐
HIP PAIN L/R/BOTH	☐	☐
LEG/FOOT PROBLEMS L/R/BOTH	☐	☐
DISC PROBLEMS	☐	☐
ARTHRITIS	☐	☐
OTHER JOINT PAIN	☐	☐
NUMBNESS/TINGLING	☐	☐
JOINT SWELLING	☐	☐

(Please CIRCLE your areas of pain)





Describe your current symptoms (dull, achy, stabbing, numbness, etc.):_____

_____

Approximately how long ago did the issues begin?

_____

What was the initial cause?

_____

_____

What is the current pain level of your symptoms:

(0=None to 10=Unbearable) _____

During the past 4 weeks, how much has pain interfered with your normal, daily activities (please circle one):

Not at all A little bit Moderately Quite a bit Extremely

In general, would you say your overall health is (please circle one):

Excellent Very Good Good Fair Poor

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Do you:

___Drink alcohol? How Often? _____ ___Smoke or Chew? How many packs per day?_____

___Vitamins/Supplements? Which ones? _____

___Consume Caffeine? How much per day? _____

___Exercise? How often? What type? _____

What percentage of time during the day do you spend:

____Lifting ____Sitting ____Bending ____Working at a Computer

List any major illnesses, injuries, auto accidents or surgeries (Women may include childbirth info) When?

_____

_____

Please list any medications you are currently taking: _____

_____

Please list any known allergies: _____

_____

Has a physician treated you for any health condition in the past year? _____

_____

Please list any other health problems you may have, no matter how insignificant you may think they are:

_____

_____

<u>Please mark any concerns you may have:</u>

___Time constraint/Busy schedule ___The chiropractic adjustment ___Financial Concerns

___How long will it take ___I have no immediate concerns

Any other information that you feel would be helpful for us to know, so we can help you with your care:

_____

_____

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	PAST	PRESENT	NO
CARDIOVASCULAR			
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			
ALLERGIES			
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
GENITOURINARY			
Kidney Disease			
Lower-Side Pain			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			
Erectile Dysfunction			
GASTROINTESTINAL			
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			
Heartburn/Indigestion			
Irritable Bowel Syndrome			
MUSCULOSKELETAL			
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
INTEGUMENTARY			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

	PAST	PRESENT	NO
RESPIRATORY			
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			
COPD			
Neurological			
Stroke			
Seizures			
Head Injury			
Brain Aneurism			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			
EARS/NOSE/THROAT			
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			
ENDOCRINE			
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			
EYES			
Glaucoma			
Double Vision			
Blurred Vision			
Cataracts			
HEMATO/LYMPH			
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fever/Chills/Sweats			
PSYCHIATRIC			
Depression			
Anxiety Disorder			
Unusual Stress			
CONSTITUTIONAL			
Weight Loss/Gain			
Energy Level Low			
Difficulty Sleeping			

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TERMS OF ACCEPTANCE

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Norton Chiropractic Center, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Financial Policy

I have read and understand the financial policy of Norton Chiropractic Center. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Norton Chiropractic Center and my insurance company. I request that Norton Chiropractic Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor(s) at Norton Chiropractic Center, that fees will be due and payable immediately. A copy of the office's financial policy is available upon request.

For our Female Patients Only:

To the best of my knowledge I **AM / AM NOT** pregnant and (**give my permission/don't give permission**) to x-ray me for diagnostic interpretation.

(Circle one above) *(Circle one above)*

Missed Appointments:

Your time is valuable and we hope that you respect our time as well.
There will be a possible fee charged for any appointments that are not canceled prior to scheduled time.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

ACKNOWLEGEMENT AND RECEIPT OF PRIVACY PRACTICES PURSUANT TO HIPAA AND CONSENT FOR USE OF HEALTH INFORMATION

I do hereby acknowledge receipt of this office's Notice of Privacy Practices Pursuant to HIPAA and have been advised that a full copy if this office's HIPAA compliance manual is available upon request.
I do hereby consent to the use of my health information in a manner consistent with the Notice of Privacy Policies Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law. Upon request I will be given a copy.

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Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? **Yes [ ] No [ ]**

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date:_____