CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

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

Attorney Name (if applicable) _____

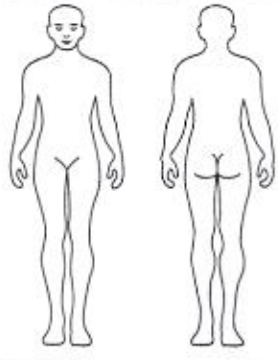
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 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 on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Sexually Transmitted Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other _____
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	
		Rheumatoid Arthritis ☐ Yes ☐ No	

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Patient Insurance / Assignment of Benefits and for use of Signature File- 2014

This authorizes the following:

1. The release of any medical information necessary to process claims.
2. The payment claims to be made directly to Karyn I. Sackstein, D.C.
3. Karyn I. Sackstein, D.C., to mark the section "Enrollee's and/or authorization person's signature" with the notation **"Signature on File."**

This authorization will remain in force until terminated by the enrollee and/or authorized person(s).

Name_____

DOB_____ SS#_____Gender_____

Address_____ City_____State____ Zip_____

Phone_____ Cell_____ Work_____

INSURANCE INFORMATION

____Private _____No Fault _____ Workers' Comp

Primary Insurance_____ID/Case # _____

Address_____ City_____ State_____ Zip_____

Phone #_____ Fax # _____ Contact _____

Insured_____ Relationship _____

Atty_____Phone_____

Secondary Insurance _____ ID/Case # _____

Address_____ City_____ State____ Zip_____

Phone #_____ Fax # _____ Contact _____

Insured_____ Relationship_____

Patient's Signature:_____ Date:_____

Dr. Karyn I. Sackstein
3051 Long Beach Rd, Ste.4, Oceanside NY 11572
516-766-1950/516-766-2371

ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

THE NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is Dr. Karyn Sackstein 516-766-1950.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the NOTICE OF PRIVACY PRACTICE form. I further understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient or Representative Name Signature: _____date:_____

Dr. Karyn I. Sackstein
3051 Long Beach Rd. Ste.4, Oceanside, NY 11572
Office: (516) 766-1950 / Facsimile: (516) 766-2371

Office Policy Notice

Dear Patient:

To provide better service for all of our patients, we now have a 24-hour cancellation policy. Please note that if you are planning to cancel your appointment, it must be made a full day in advance so that we may utilize your time slot to treat other patients. Failure to notify the office in a timely fashion will result in a $20.00 cancellation fee, which is not covered by insurance.

_____
Initial

Please be advised that we provide the following services such as; ultrasound, muscle stimulation, and traction in an open treatment room. An open treatment room reduces wait time and enables us to provide faster treatment for all our patients. It is our policy that we will not discuss any personal information in this treatment room. If you wish to discuss personal information, let the front desk know and you will be placed in a private room.

_____
Initial

In closing, please note that our office will follow-up on patients in the event that we do not see you, either via e-mail_____ or
Text: _____(cell phone provider)_____in order to make sure that no problems have developed. Your good health is important to us.

_____
Initial

Thank you for your cooperation in the above matters.

Sincerely,

Dr. Karyn I. Sackstein

_____
Patient's Signature and Date

Karyn I. Sackstein D.C.
3051 Long Beach Road
Oceanside, NY 11572

INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed of treatment.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE ARE:

STROKE: Stroke is the most serious complications of chiropractic treatment. It is rare. According to the journal of CCA, Vol. 37, No. 2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine. Therefore, cervical treatment poses a small risk for a stroke, which is temporary or permanent brain dysfunction. On extremely rare occasions death occurs.

SORENESS: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but please advises your doctor of chiropractic of the soreness.

SOFT TISSUE INJURY: Occasionally chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue injury.

RIB INJURY: Manual adjustments of the thoracic spine, in rare cases may cause a rib injury or fracture. Precautions such as pre-adjustment X-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

PHYSICAL THEARAPY BURNS: Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported, as well as other side effects you may be experiencing.

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.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include gastrointestinal bleeding, kidney and liver disease as well as other undesirable side effects 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.
- *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.

Karyn I. Sackstein D.C.
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Risks of remaining untreated: Delay of treatment allows formations 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.

Unusual Risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

I have reviewed the risks of my treatment, alternative forms of treatment as well as remaining untreated with patient. I have also afforded the patient the opportunity to ask any questions and have answered them to their satisfaction.

Patient Signature:_____

Printed Name: _____ Signature Date: _____

Doctor signature :_____

Printed Name: Dr. Karyn I. Sackstein Signature Date:_____