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) _____

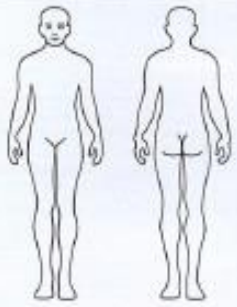
5 PATIENT CONDITION

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	
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Other _____
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		

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

Sailer chiropractic

Tonia M. Sailer D.C. 952-895-4085

PATIENT NAME: _____

HIPPA Acknowledgement

My signature below indicates that I have been provided a copy of the HIPPA Notice of Privacy practices and have read the clinics policy regarding HIPPA privacy.

Patient Signature:_____ **Date:_____**

(Guardian signature if minor)

Voicemail and Texting Preference

Sailer Chiropractic Center uses telephone calls and texting to communicate about appointments and various health information.

Please **CHECK** all methods of communication that Sailer Chiropractic can use to contact you.

Please CIRCLE your preferred method

_____ Calling (Home, Mobile, Work)

_____Texting (Mobile)

I give permission for Sailer Chiropractic Center to call and leave voicemails and/or text messages to my phone regarding appointments and health information. I understand message and data rates may apply.

Patient Signature:_____ **Date:_____**

(Guardian signature if minor)

Sailer chiropractic

Tonia M. Sailer D.C. 952-895-4085

Authorization and Assignment of Benefits Office Policy

Please initial on the lines and sign the bottom

1. _____In exchange for services and supplies rendered, I do assign Sailer Chiropractic Center any insurance proceeds, Including accident and health insurance, auto insurance benefits and bodily injury claim award up to the amount of any unpaid balance on my account. In giving this assignment I acknowledge that I am responsible for all charges to my account.
2. _____With my signature on this authorization, I am agreeing to allow Sailer Chiropractic Center to direct my insurance company to make any payments for my chiropractic, physiotherapy, physical rehabilitation, diagnostic testing or any other reimbursable treatment or evaluations I receive to Sailer Chiropractic Center directly.
3. _____I understand and agree to pay a $5.00 monthly service charge on any outstanding balance over 30 days old.
4. _____By signing this, I am authorizing Sailer Chiropractic to release any information contained in my file to any insurance company, attorney, adjuster, or member of our office staff, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required.
5. _____I agree to pay any and all amounts not paid by the insurance company. If any action must be taken by Sailer Chiropractic Center to enforce its rights under this authorization and assignment of benefits, I understand that I may be held responsible for any reasonable costs incurred by taking such action.

Patient Name (print): _____

Patient Signature:_____ Date:_____

(Guardian signature if minor)

Sailer chiropractic

Tonia M. Sailer D.C. 952-895-4085

Informed Consent

Print Name:_____

Almost all chiropractic treatment includes chiropractic adjustments, a specific manipulation of joint. Like most healthcare procedures, there are risks associated with chiropractic treatments. The serious risks associated with chiropractic adjustments are extremely rare. The following are known risks of chiropractic treatment.

Temporary soreness or increased symptoms of pain: It is not uncommon for patients to experience temporary soreness or increased symptoms following a treatment.

Bruising: Soft tissue manipulation or instrument assisted soft tissue treatment may result in bruising.

Dizziness, nausea, flushing: Although rare, it is important to notify the doctor if you are experiencing symptoms of dizziness, nausea or flushing

Fractures: If patients have an underlying condition such as osteoporosis, they may be susceptible to fractures. It is important that you notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such conditions while you are under their care, your will be informed, and your treatment plan will be modified to minimize fracture risk.

Disc herniation or prolapse: Spinal disc conditions such as a disc bulge or herniation may worsen with chiropractic care. It is important you notify your chiropractor if your symptoms change or worsen.

Stroke: In rare cases a certain rare type of stroke has been associated with chiropractic care. Although there is an association between chiropractic visits and this rare stroke, there are also an association between this stroke and primary care visits. According to the most recent research, there is no evidence of excess risk to stroke associated with chiropractic care (If you are interested in this research please see Dr. Sailer or her staff). The increased occurrence of the type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting with both doctor of chiropractic and primary care medical doctors before or during the stroke.

Other risks: associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Patient Signature:_____ **Date:**_____

(Guardian Signature of minor)

Consent to Treat a Minor

I,_____, the parent/guardian having legal custody/ legal guardianship of the above named child, do herby authorize Sailer Chiropractic Center to evaluate and treat as deemed advisable by Dr. Tonia Sailer.

Parent/Guardian Signature:_____ **Date:**_____