Ferguson Chiropractic Center

Patient Registration Information

Date_____Name_____

Soc. Sec. # _____ Date of Birth _____ Age _____

Address_____ Home Phone _____

City _____ State_____ Zip _____ Cell phone_____

Sex _____ () Single () Married () Widowed () Divorced () Minor

Email_____

Primary Language _____ Race_____ Ethnicity _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Spouse's Name _____ Employer _____

Referred by:_____

Person Responsible for the bill _____

Relationship to Patient _____ Date of birth _____ Soc. Sec. # _____

Insurance Company _____ Group # _____

Insurance Company Address _____ ID # _____

In case of emergency, whom should we contact? _____phone:_____

Assignment and Release

I hearby authorize payment directly to Ferguson Chiropractic Center and/or Dr. Jon Ferguson all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance for all services rendered on my behalf or my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Ferguson Chiropractic Center and/or Dr Jon Ferguson to disclose and send health information concerning myself or my dependents via the internet/email to the email listed above.

Signature of Responsible Party _____ Date_____

Ferguson Chiropractic Center Patient History

Print Patient Name: _____ Signature_____ Date:_____

Past Medical History

Check any condition which you currently have or have had in the past.

_____ Aids/HIV	_____ Concussion	_____ Migraine Headaches	_____ Stroke
_____ Alcoholism	_____ Depression	_____ Miscarriage	_____ Surgery
_____ Allergy Shots	_____ Diabetes	_____ Mononucleosis	_____ Thyroid Problems
_____ Anemia	_____ Emphysema	_____ Multiple Sclerosis	_____ Tonsillitis
_____ Anorexia	_____ Epilepsy	_____ Mumps	_____ Tuberculosis
_____ Anxiety	_____ Fractures	_____ Osteoporosis	_____ Tumor/Growth
_____ Appendicitis	_____ Glaucoma	_____ Pacemaker	_____ Ulcers
_____ Arthritis	_____ Goiter	_____ Parkinson's Disease	_____ Vaginal Infection
_____ Asthma	_____ Gout	_____ Pinched Nerve	_____ Whooping Cough
_____ Auto Accident	_____ Heart Disease	_____ Pneumonia	_____ Use Tobacco Products
_____ Bleeding	_____ Hepatitis	_____ Polio	_____ More than 1 alcoholic drink per day
_____ Breast Lump	_____ Hernia	_____ Prostate Problems	
_____ Bronchitis	_____ Herniated Disc	_____ Prosthesis	Other/Explain: _____
_____ Bulimia	_____ Herpes	_____ Psychiatric Care	_____
_____ Cancer	_____ High Blood Pressure	_____ Rheumatoid Arthritis	_____
_____ Cataracts	_____ High Cholesterol	_____ Rheumatic Fever	_____
_____ Chemical Dependency	_____ Kidney Disease	_____ Shingles	_____
_____ Chicken Pox	_____ Measles	_____ STD	_____

List Surgeries and Dates:_____

_____

Have you been treated by any physician for any condition within the past year? Yes No

If yes, please describe:_____

Date of last physical exam: _____ Is there a chance you are pregnant? Yes No

Please list all medications you are currently using (including nutritional supplements): (Please print)

_____

_____

_____

Any Allergies Yes No If yes please list: _____

Family History

Were you adopted? Yes No

Please briefly describe any past or present health conditions of your family members:

Grandparents –

Mother –

Father –

Siblings –

Children -

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Ferguson Chiropractic Center, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services.)
*Your name, address, phone number, email address, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to provide other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you.

*Your health care and personal information may be discussed and disclosed with other people being present, if you allow them to accompany you to any room other than the waiting/reception area. If other people are with you and you wish to discuss matters in private, you must specifically express that you wish to discuss matter in private to the Doctor or Staff at the time of the service. You have the right to refuse to provide authorization to allow other people present during your care. If you do not provide us with this authorization, it will not affect the care provided to you.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other an as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time your receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Jon J. Ferguson.

If you would like further information about our privacy policies and practices please contact Dr. Jon J. Ferguson.

This notice is effective as of today's date.

_____ _____ _____

Name (Printed Please) Signature Date

If you are a minor or if another party is representing you

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.