6605 Pittsford-Palmrya Road, Suite E9 Fairport, NY 14450 P: 585-223-1580 F: 585-223-1582

PATIENT REGISTRATION

Date:_____ Main phone:_____Work Phone:_____Email:_____

Patient Last Name:_____First Name:_____Initial:

Address:_____

City:_____State: Zip:_____Age: Birth Date:_____

Sex ☐ Male ☐ Female ☐ Single ☐ Married

Primary Insured name:_____Relationship to Insured(circle): Self Spouse Child Other

Condition or Illness related to:

☐ Injury ☐ Auto accident ☐ Work accident ☐ Personal Injury ☐ Other

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INSURANCE INFORMATION

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have.
Insurance company or health care plan name:_____

Name of Primary Subscriber Insured:_____**ID#**:_____

Date of Birth of Primary subscriber:_____Effective Date:_____

Are your present symptoms or conditions related to or the result of an auto accident, work related injury or other personal injury that someone else might be legally liable for? YES_____or NO_____

If yes please inform the doctor or front desk for correct legal forms

Medical Information

Pregnant ☐ **Pacemaker** ☐ Family Physician or Primary Doctor:_____

Contact person for emergency (name and phone):_____

Attorney if need be:_____Phone:_____

1. Primary Health Concern to seek care today: _____

_____ Pt Name

2. Onset: When/how did you first notice your symptoms: _____

_____

3. Duration and timing: ☐ Constant ☐ Frequent ☐ Occasional

3. Intensity of Symptoms: Absent 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Agonizing

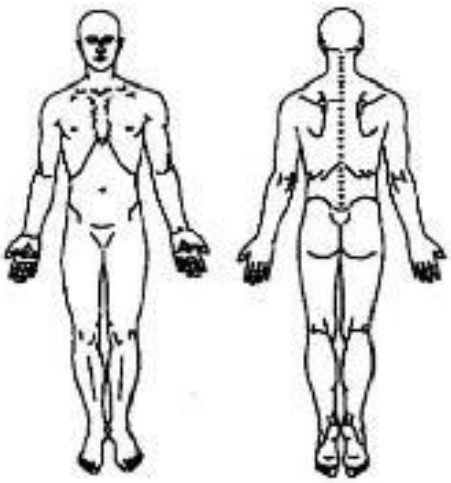
4. Quality of Symptoms:

Match symptoms with location using symbols

Numbness____	Tingling____
Stiffness____	Dull____
Aching____	Cramps____
Nagging____	Sharp____
Burning____	Shooting____
Throbbing____	Stabbing____
Other:_____	

Where does it hurt?

Please draw on diagram



5. Radiation- Does it affect other areas? Does the pain radiate, shoot or travel?

_____

6. What tends to lessen or relieve the problem?

_____

7. What tends to increase or aggravate the problem?

_____

8. Prior Interventions:

Prescription Medication:	Over the counter drugs:
Physical Therapy:	Surgery:
Acupuncture:	Chiropractic:
Massage:	Ice or Heat:
Other:	

9. What else should we know about your current condition? _____

_____ Dr. Initials

10. Effects on sleep: Does pain wake you up? _____

HEALTH GOAL: What would be the most important thing to accomplish to improve your health?

_____

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Review of Systems

Please check any symptoms you've HAD or currently HAVE

Pt name

1. Musculoskeletal:

Osteoporosis___ Scoliosis___ Neck Pain___ Back Problems_____ Hip Disorders___
Knee Injury_____ Foot/ankle Injury___ TMJ_____ Elbow/ wrist_____ Shoulder Pain___

2. Neurological:

Headaches_____ Dizziness_____ Pins and Needles_____ Numbness_____

3. Cardiovascular:

High Blood Pressure___Low Blood pressure____ High cholesterol ___ Excessive bruising_____
Poor circulation_____ Angina____ Fainting_____

4. Respiratory/Digestive:

Asthma_____ Emphysema_____ Shortness of breath_____ Ulcer_____ Heartburn___
Food sensitivities_____Anorexia/Bulimia____ Constipation_____ Diarrhea:_____

5. Sensory:

Blurred vision____ Ringing in ears_____ Hearing loss____ Loss of smell or taste:_____

6. Endocrine:

Thyroid issues_____ Immune disorders____ PMS Symptoms____ Swollen glands
Low energy or Fatigue_____ Kidney stones____

MEDICAL HISTORY

A. Surgeries or Operations: _____

B. Illnesses or diseases currently experiencing or have had in the past:

C. Past Injuries: Fractured or broken bone:_____Spine or Nerve Disorder_____

Knocked unconscious:_____Used neck or back Bracing:____

Injured in an accident:_____

D. List all current medications or supplements: _____

E. Family and social history:

Known health Issues that are hereditary?_____

Dr. Initials

Effects your symptoms have on Daily Living: Circle one for each activity listed below:

Sitting	none	mild	moderate	severe	**Standing**	none	mild	moderate	severe
Walking	none	mild	moderate	severe	**lying down**	none	mild	moderate	severe
Bending over	none	mild	moderate	severe	**Climbing stairs**	none	mild	moderate	severe
Driving	none	mild	moderate	severe	**Caring for family**	none	mild	moderate	severe
House work	none	mild	moderate	severe	**Lifting objects**	none	mild	moderate	severe
Sleep	none	mild	moderate	severe	**Working**	none	mild	moderate	severe

Any other effects on your daily life:_____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment of Benefits and Designation of Authorized Representative

In considering the amount of medical expenses to be incurred, 1, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. 1 understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. 1 hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. 1 hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named providers'), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (I) obtaining information about the claim to the same extent as the assignor'; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plants), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern

If patient is a minor, child's full name**:**_____

Signature of patient or legal guardian:_____**Date**_____