Rochester Chiropractic & Pregnancy

Patient Registration & History

First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Gender (circle one): Male / Female Marital Status (circle one): M-S-D-W

Home No.: (___)_____ Cellular No.: (___)_____ Work No.: (___)_____

Employment Status (circle one): Full time / Part time / Retired / Not employed / Self-employed / Student

Employer: _____

Employer's Address: _____

Dominant Hand (circle one): Left / Right / Both

EMERGENCY CONTACT: _____ Phone No.: (___)_____

Relationship: _____

Primary Care Physician: _____ Phone No.: (___)_____

Address: _____

Female Patients: OB/GYN: _____ Last Date Seen: _____

Address: _____ Phone No.: (___)_____

Are you currently pregnant or trying to become pregnant? YES/NO If pregnant, Due Date: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____
Subscriber ID #: _____ Subscriber's Name: _____
Subscriber's Date of Birth: _____ Relationship to Patient: _____
Secondary Insurance: _____ Effective Date: _____
Subscriber ID #: _____ Subscriber's Name: _____
Subscriber's Date of Birth: _____ Relationship to Patient: _____

Assignment of Benefits & Authorization:

I, the undersigned certify that I (or my dependent) have insurance coverage with the company(s) stated above, and I assign office of Dr. Nicole Clemente all insurance benefits directly, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, including any settlement made in my behalf. **Initial** _____ I hereby Authorize the Practice/Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. If I have supplied the wrong insurance information or failed to provide up-to-date information I understand there will be a $10 charge added to my account and I accept full responsibility for the total charge of my medical appointment. **Initial** _____ All payments are due on the date of service. There will be a $10 charge for nonpayment. **Initial** _____ After 60 days if payment has not been received this office reserves the right to send your bill to collections. If this occurs, you will be responsible for our fees and any fees from the collections agency. I affirm that the information I have provided above is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in this medical status. A copy of this signature is as valid as the original.

X Signature: _____ Date: _____
Witnessed: _____ Date: _____

Patient Condition

Reason for visit: _____

_____

_____

When did you symptoms appear? _____

Is your condition getting … (Circle) Better? Worse? Staying the Same?

Rate your pain on a scale from 1 (least pain) to 10 (severe pain): Now: _____ At its worst: _____

What are you feeling? (circle all that apply) Sharp Dull Throbbing Numbness Aching Cramping Burning Tingling Stiffness Stabbing Dizzy Spasms

Other: _____

How often do you experience this problem? _____

Is this constant or does it come and go? _____

Does it interfere with your: (circle) Work Sleep Daily Routine Recreation Other: _____

Painful Activities: Sitting Standing Walking Bending Lying Down Sleeping Other: _____

What treatments have you received for this? _____

Health History

Do you exercise? YES/NO If yes, What? _____

Caffeine, cups per day: _____ Do you Smoke: Y/N Frequency: _____ Alcoholic beverages per week:_____

Please list ALL Medications, Vitamins, Minerals and/or Herbs you are currently taking: _____

_____

_____

Please list ALL Surgical procedures, Broken Bones, Head Injuries and Hospitalizations: _____

_____

_____

Please list ALL Allergies: _____

_____

Family History

Please circle if immediately family members (Grandparents, Parents, Siblings) have any of these diagnosis?

Heart Disease	Kidney Disease	Circulation Problems	Migraines	High Cholesterol
Arthritis	Stomach Problems	Thyroid Disease	Stroke	
Rheumatoid Arthritis	Osteoporosis	Mental Illness	Lung Disease	
Seizures	High Blood Pressure	Cancer (Specify): _____		
Diabetes	Back Problems	Other, Not Listed: _____		

Have you had in the past or currently have any of the following conditions: (circle all the apply)

General Fatigue	Bladder Infection	Joint Swelling/Stiffness	Birth Control, Type_____
Depression	Frequent Urination	Arthritis	Breast Soreness
Dermatitis/Rash/Eczema	Painful Urination	Rheumatoid Arthritis	Breast Lumps
Asthma	Prostate Problems	Angina	Irregular Menstrual Flow
Chronic Cough	Kidney Disease	Heart Attack, Date: _____	Profuse Menstrual Flow
Emphysema	Kidney Stones	Aortic Aneurysm	PMS
Chronic Sinusitis	Loss of Bladder Control	High Blood Pressure	PCOS
Difficulty Swallowing	Loss of bowel Control	High Cholesterol	Endometriosis
Excessive Thirst	Constipation/Diarrhea	Rapid Heart Beat	Poly Cystic Ovarian Disease
Diabetes	Irregular Bowel Habits	Stroke, Date: _____	Number of Pregnancies ___
Headaches	Irritable Colon	Abnormal Weight	Number of Births ____
Migraines	Colitis	Gain/Loss	Tumor, Explain _____
Jaw Pain/ TMJ	Hepatitis, Type: _____	Anorexia/Bulimia	_____
Tinnitus (ringing in ear)	Liver/Gallbladder	Abdominal Pain	Cancer, Type_____
Visual Disturbances	Thyroid Disease	Loss of Appetite	_____
Dizziness	Ulcer	HIV/AIDS	Other, not listed _____
Respiratory Disease	Blood Disorder, Type____	Epilepsy	_____
Lupus	Osteoporosis	Fainting	_____

<u>If UNDER 18, Provide Consent to Treat a Minor:</u>

I hereby authorize Dr. _____ and whomever he/she may so designate as his/her assistant(s) to administer treatment as the Doctor deems necessary for my Son/Daughter (circle one), _____. I (parent/guardian), will personally be responsible for all payments, co-pays and/or deductibles that are not covered by our insurance and be responsible to keep insurance information up-to-date with this office. **Name of Parent/Guardian**: _____

Signature of Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____

<u>HIPPA</u>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (PRINT Patient's Name) am aware that at anytime I can request a copy of the HIPPA Notice of Privacy Practices. You may refuse to sign this acknowledgement.

Signature of Patient: _____Date:_____

Signature of Power of Attorney: _____ Date: _____