# Patient Registration Form

***Whom may we thank for referring you?*** Internet / Facebook/Other advertising / Friend

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Information | **Patient Information** | | | | | | |
| First Name and Middle Initial: | | Last Name: | | | | Previous Name (if applicable): |
| Mailing Address: | | | | | | Apt # |
| City / State / Zip: | | | | | E-Mail Address: | |
| Home Phone: | Cell Phone: | | | | | Work Phone: |
| **Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:**  *Phone: Text Message: E-mail:*  Provider: AT&T, Cricket, Sprint, Verizon, Other: | | | | | | |
| Can we leave a message regarding your medical care & test results? Yes / No | | | | | | |
| Current Family Physician or Pediatrician: | | | Date of Birth: | | | Sex: Male / Female |
| Marital Status: | Social Security Number: | | | | | |
| Employer name and address: | Emergency Contact Name: | | | | | Relationship to Patient: |
| Emergency Contact Phone Number: | | | | | |
| Responsible Party and Additional Information | **Responsible Party** – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor | | | | | | |
| First Name: | Middle Initial: | | | | | Last Name: |
| Date of Birth: | Social Security Number: | | | | | Phone: |
| Address of Person Responsible: | | | | | | |
| City / State / Zip: | | | | | | Relationship to Patient: |
| **Additional Information** (PLEASE FILL OUT ALL SECTIONS BELOW) | | | | | | |
| Race (please circle):  White American Indian or Alaska Native Asian  Hispanic Black or African American Native Hawaiian or Pacific Islander Other Decline | | | | | | Ethnicity (please circle one):  Hispanic or Latino Not Hispanic or Latino Decline |
| Preferred Language (please select one): English Bosnian Indian (including Hindi & Tamil)  Sign Language Spanish Russian Other | | | | | | |
| Preferred Pharmacy Name & Location: | | | | | | |
| Insurance Information | **Primary** Insurance | | | | **Secondary** Insurance | | |
| Insurance Company Name: | | | | Insurance Company Name: | | |
| ID number and Group Number or Claim Number: | | | | ID number and Group Number or Claim Number: | | |
| Policy Holder Name: | | | | Policy Holder Name: | | |
| Policy Holders Date of Birth and Social Security Number: | | | | Policy Holders Date of Birth and Social Security Number: | | |
| Patient Relationship to Policy Holder: | | | | Patient Relationship to Policy Holder: | | |
|  |  | | | |  | | |

Signature of Responsible Party: X

Printed Name of Responsible Party: X



**Release of Information**

* I Authorize the release of information including the diagnosis, records, examination rendered to me, billing, and claims information.

This information may be released to (list the names of the individuals):

* Spouse:
* Child(ren):
* Parent:
* Other:

# My information is not be released to anyone.

***This Release of Information will remain in effect until terminated by me in writing.***

Signature: Date:

**NOTICE OF PAYMENT POLICY** I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Flaskey Chiropractic (FC) all money to which I am entitled for medical expenses related to the services performed from time to time by FC, but not to exceed my indebtedness to FC. I authorize FC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

A $40 returned check fee will be charged for checks returned due to insufficient funds. Flaskey Chiropractic reserves the right to charge

$35 for missed appointments or canceled appointments without a 24-hour notice.

(initials) I Certify that I have read and agree to Flaskey Chiropractic’s Payment Policy above

(initials) I have reviewed a copy of Flaskey Chiropractic’s Privacy Notice

# Patient Information Sheet

NAME: DOB: DATE: ALLERGIES:

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and

when taken. If you don’t know, please call your pharmacist to confirm.

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| ADHD | COPD/Emphysema | High Cholesterol | Rheumatoid Arthritis |
| Alcoholism | Dementia | HIV | Seizure Disorder |
| Allergies, Seasonal | Depression | Hepatitis | Sleep Apnea |
| Anemia | Diabetes: 1 or 2 | Irritable Bowel Syndrome | Stroke |
| Anxiety | Diverticulitis | Lupus | Thyroid disorder |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot) | Liver Disease | Ulcerative Colitis |
| Arthritis | GERD (Acid Reflux) | Macular Degeneration | Other: |
|  |  |  |  |
| Asthma | Glaucoma | Neuropathy |  |
| Bipolar | Heart Disease | Osteopenia/Osteoporosis |  |
| Bladder Problems/Incontinence | Heart Attack (MI) | Parkinson’s Disease |  |
| Bleeding Problems | Hernia | Peripheral Vascular Disease |  |
| Cancer:  Headaches | High Blood Pressure  Kidney Stones | Peptic Ulcer  Psoriasis |  |
| Crohn’s Disease | Kidney Disease | Pulmonary Embolism (PE) |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Menstrual Period | Date: | Normal / Abnormal | Pregnant? | Yes/No Due Date: |
| Pap | Yes/No Date: | Normal / Abnormal | Trying to conceive? | Yes/No |
| Mammogram | Yes/No Date: | Normal / Abnormal | Children? | How many? |
| DEXA (Bone Density Scan) | Yes/No Date: | Normal / Abnormal |  | |
| Colonoscopy | Yes/No Date: | Normal / Abnormal |

SURGICAL HISTORY: Please list all your prior surgeries and approximate dates performed.

List all medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.):

## FAMILY HISTORY:

**FATHER:** Living: Age Deceased: Age

Alcoholism Bipolar Disorder Depression High Cholesterol Osteoporosis Anemia Cancer: Diabetes 1 or 2 High Blood Pressure Stroke Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder Arthritis

Dementia Heart Disease Migraines

Other:

**MOTHER:** Living: Age Deceased: Age

Alcoholism Bipolar Disorder Depression High Cholesterol

|  |  |  |
| --- | --- | --- |
| Osteoporosis | Anemia | Cancer: |
| Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (blood clot) Kidney Disease |
| Thyroid Disorder | Arthritis | Dementia Heart Disease Migraines |

Other:

## SIBLINGS:

**SOCIAL/CULTURAL HISTORY:**

Education Level:

Elementary

High School

Vocational

College

Graduate / Professional

Are there any vision problems that affect your communication? Yes / No Are there any hearing problems that affect your communication? Yes / No

Are there any limitations to understanding or following instructions (either written or verbal)? Yes / No Current Living Situation (circle all that apply):

Single family household / Multi-generational Household / Homeless / Shelter / Skilled Nursing Facility / Other:

Smoking / Tobacco Use:

Current

Past

Never Type: Amount/day: Number of Years:

Vaping:

Current

Past

Never Type: Amount/day: Number of Years:

Alcohol:

Current

Past

Never Drinks/week:

Recreation Drug Use:

Current

Past

Never Type:

Are you sexually active? Yes / No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes / No Are there any cultural or religious concerns you have related to our delivery of care? Yes / No

Are there any financial issues that directly impact your ability to manage your health? Yes / No

How often do you get the social and emotional support you need? Always / Usually / Sometimes / Rarely / Never

Comments (please feel free to comment on any answers marked “yes” or circled above):

**Patient Signature: Date:**

# Patient Condition

## NAME: DOB: DATE:

**Reason for Visit:**

**What caused your symptoms?**

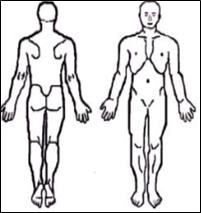
**When did your symptoms appear (date)? This condition is getting (please circle one):** Worse / Better / Unchanging

**Type of pain (Circle all that apply):**

|  |  |  |  |
| --- | --- | --- | --- |
| Aching | Dull | Shooting | Throbbing |
| Burning | Numbness | stiffness | Tingling |
| Cramping | Sharp | Swelling | Other: |

**How often do you have this pain?**

**Circle/Mark on the picture where you have pain, numbness, or tingling**



**No Pain**   **Worst Pain**

**Mark an X on your degree of pain**

**Does it interfere with your (Circle all that apply)?** Work / Sleep / Daily Routine / Recreation

**Is there anything that makes the pain better?**

**Activities or movements that are painful to perform (Circle all that apply):**

Sitting / Standing / Walking / Bending / Lying Down / Other:

**Informed Consent**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications, while rare, may include: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, or burns. Fractures are extremely rare and generally result from some underlying weakness of the bone, usually stemming from a hidden disease process, which are checked for during the taking of your history and during examination and x- ray, if clinically indicated. There are many wonderful benefits to chiropractic care and remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. Other treatments available are self-administered over the counter analgesics, rest, prescribed drugs, hospitalizations, or surgery.

I have read or have had read to me the above explanation of chiropractic care and related treatment. I have discussed it with my doctor and have had my questions answered. Having been informed of any risks, I hereby give my consent to treatment with Flaskey Chiropractic & Acupuncture.

**Patient signature (parent or guardian) Date Dr. Signature Date**