CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

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, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

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)_____

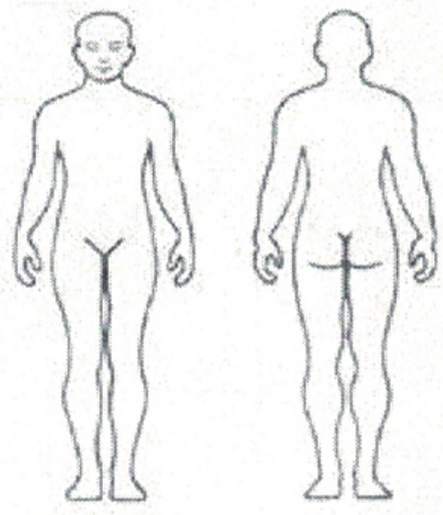
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



– OVER –

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	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____	
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Measles	☐ Yes ☐ No				
Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ 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		

7 MEDICATIONS

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS

O'LAIRE CHIROPRACTIC

106 Saraland Loop • Saraland, AL 36571
(251) 679-1995 • (251) 679-9282 FAX

Please complete the following information:

Patient Name: _____
Address: _____
_____

Phone # _____
SSN: _____ DOB: _____

Requesting Records from: _____ I authorize the custodian of records to disclose/release the following information.

_____All records	_____Abstract Summary	_____Billing records
_____Lab/Path records	_____Pharmacy/RX records	_____X-ray/Radio
_____Other_____		

Please send the records to: O'Laire Chiropractic
106 Saraland Loop
Saraland, AL 36571
(251)679-1995 Phone (251)679-9282 Fax

This information may be used/disclosed for each of the following purposes:

_____At my request _____For my healthcare _____Other

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal privacy law. I further understand that this information is voluntary and that I may refuse to sign this authorization. I understand that HIV, Alcohol and Drugs tests may be included in records requested. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there is no claim to orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

X
_____ Date: _____
Signature or patient
(Or patients' personal representative)

X
_____ _____
Printed Name representatives' authority to sign.
(Parent, guardian, POA, etc.)

O'Laire Chiropractic

Financial Obligation/Assignment of Benefits

It is your responsibility to inform the front desk of all updates to your insurance plan as well as your personal information. Failure to do so could result in charges becoming patient responsibly. I assign and authorize payments to O'Laire Health Solutions, also known as O'Laire Chiropractic or OHS.

It is your responsibility to understand your insurance plan. Please make sure to contact your insurance provider to determine if OHS is in network and covered under your insurance plan. It is your responsibility to know what your deductible, copay, percentages, and other related expenses for treatment are. Be aware that our office has different types of providers. It is your responsibility to know if services related to treatment for Chiropractic, Physical Therapy, and Physical Therapy Assistant are covered under your insurance policy.

Our fees are considered usual, customary and reasonable by most companies.

You are responsible for the payment of charges for the health care we provide. Unless your health insurance company, HMO, or Medicare agreement with O'Laire Health Solutions prohibits it, payment is due at the time of visit. Our office accepts cash, credit card, and check payments. Patient that does not have benefits through a third party may speak with the front desk attendant regarding our fees.

By Signing this document, I acknowledge that I am responsible for the financial obligation arising from the provision of care to myself, or the person for whom I am acting as a personal representative (such as an unemancipated minor). I am assigning and authorizing payments to O'Laire Health Solutions. If your carrier has not paid claim within sixty days of submission, you agree to take and active part in recovery of your claim. There cloud/will be a rebilling fee of 30% of the total charges added to all accounts not paid in full within 90 days of service. I acknowledge I will incur the reasonable costs of collections including attorney's fees should I fail to satisfy my financial obligation.

HIPAA Privacy Notice/Communications

OHS requires a signed consent before sharing medical information with a third party. For exclusions to this policy, please ask a front desk staff member for a copy of our Notice of Privacy Practices. Details regarding the protection of patient privacy are detailed on that document. There are times when OHS will need you in order to provide you with appointment details and x-ray results. If you would like to opt out of receiving calls from us, please let us know. Otherwise, we will use the number provided to contact you. By signing below, you agree that in order to service your account or collect monies owed. OHS and/or agents may contact you by telephone at any number associated with your account, including wireless numbers, which could result in charges to you. You may also be contacted through text messages or emails, if you provide them. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Testing/Consent to Treatment

Your physician will determine what treatment is most appropriate to address your symptoms and conditions. I voluntarily consent to the rendering of care, including treatment and performances of diagnostic procedures performed by the doctor or staff as appropriate. I understand OHS may refer me for diagnostic test (such as MRI) outside the office. I give consent for OHS to use my information to arrange such test, and I give consent that the results be released back to OHS for review. I understand the potential risk and consent to treatment. I understand I am free to ask questions about my treatment at any time. It is always your right to refuse any recommended treatment.

Additional Medicare Consent

I certify that the information given by me in applying for payment under Title XVIII and /or Title XI of the Social Security Act is correct. I authorize and holder of medical or other information about me, to release to the Social Security Administration or other intermediary carries, and information needed for this or related Medicare claim.

Female Waiver

By my signature below on this form I do herby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. Or if I am pregnant, I will notify all technicians who will be performing X-rays or any other procedures.

I understand by signing this for, I am authorizing OHS to treat me if I seek treatment or until I withdraw my consent in writing.

Patient Signature: _____ Date: _____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____