CHIROPRACTIC PATIENT REGISTRATION & HISTORY

PATIENT INFORMATION

Today's Date: ___/___/____ Sex: Male / Female

Patient Name: _____

Birthdate: ___/___/_____ SS#: ____ - ____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Married: Y / N Spouse's name: _____

Kids: Y / N If yes, how many: _____

Occupation: _____

Email: _____

Cell: (___) ____ - _____ Home: (___) ____ - _____

In case of an emergency, contact: (___) ____ - _____

_____

Whom may we thank for referring you?

INSURANCE INFORMATION

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with:

_____

(Name of Insurance Company)

Dr. Brian E. Jones will provide 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 my insurance. I agree to receive all communications in electronic format. I also authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Sign Here: _____

(If under 18, parent/guardian sign instead)

PATIENT CONDITION

Reason for Today's Visit: _____ When did symptoms appear? _____

How often do you experience pain? Nonstop_____ Frequently_____ Moderately_____ Occasionally____

Rate the severity from 1 (least) to 10 (most): _____ First time you had this pain: _____

Are you experiencing these symptoms: Headaches__ Tingling__ Numbing__ Stiffness__ Aching__ Cramps___

Does it interfere with your: Work____ Sleep____ Daily Routine____ Recreation____ Sports ____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes / No What was the date of injury: ___/___/____

Please specify what type of accident: Auto_____ Work_____ Home_____ Work____ Other: _____

Has the accident been reported? Yes / No If yes, what is the claim number? _____

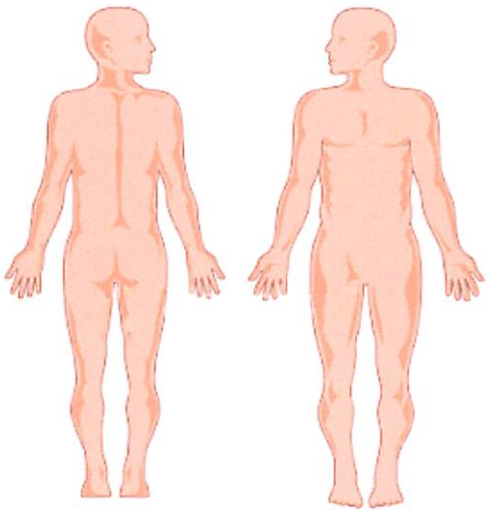
Attorneys Name: _____ Phone Number: (____) _____ - _____

PATIENT HISTORY

Patient:_____ Date:_____

CHECK SYMPTOMS YOU HAVE:

- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Fatigue
- ☐ Dizziness
- ☐ Head too heavy
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness in Fingers/Toes
- ☐ Shortness of Breath
- ☐ Sleeping Problems
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Face Flushed
- ☐ Buzzing in Ears
- ☐ Loss of Balance
- ☐ Fainting



(Mark "X" where pain symptoms are)

- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Upset Stomach
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Fever
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Neuritis
- ☐ Digestive Disorders
- ☐ Sinus Trouble
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Cancer

Other Symptoms, Remarks & Additional Information:_____

_____

Medications/drugs you are taking, if any: _____

DO NOT WRITE BELOW THIS LINE - DO NOT WRITE BELOW THIS LINE - DO NOT WRITE BELOW THIS LINE

History of Injury (Date of Injury/Onset:_____)

Surgeries

Past History

Fractures

Auto Accidents

Illnesses

Work Injuries

Happened before?

Any position/activities offer relief? Any aggravate?

Pain worst at day/night?

What have you done for this condition?

Anyone recommend surgery?

Jones Family Chiropractic

17090 Avondale Way NE - Redmond, WA 98052
(425)882-0802

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully undserstand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

SIGN: _____ DATE: ___/___/_____

CANCELLATION & NO SHOW POLICY

Thank you for choosing Jones Family Chiropractic Center as your chiropractic health provider. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Read the following policies, and then sign your name at the bottom of the page.

Please remember that we have reserved appointment times *especially for you.* Therefore, we request **at least 24 hours notice** in order to reschedule your appointment. If you are unable to keep your appointment, *please notify us as soon as possible*. Our answering machine is on 24 hours a day. This will enable us to offer your cancelled time to other patients that need care.

When you cancel your appointment at the last minute, everyone loses - you, the doctor, and other patients that would like to utilize our time.
We value your time, so please value ours as well.

CANCELLATION:
Notice must be given *NO LATER* than 8:30 am the day of your appointment. The fee for not following the cancellation policy is $10.00. Payment for the broken or cancelled appointment is not covered by insurance and is the responsibility of the patient. (Exceptions to the cancellation policy will be granted for the following reasons: Medical emergencies, illness, car accidents, and funerals.)

NO SHOW:
If you do not show up for your appointment you will be charged a 20$ no-show fee.

LATE ARRIVAL:
If you arrive late to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.

I understand and accept the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and cannot be billed to my insurance company.

Sign:_____ Date: ___/___/_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of the County Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to by used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnesses by:_____

_____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____