

ASHLAND CHIROPRACTIC CENTER, INC.

1182 Twp. Rd. 1175 Ashland, OH 44805

Dr. Robert Bachelder, D.C., FACO

419-289-8592

Patient Registration

Name:(FIRST, LAST, M.I.)_____ Date: _____

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

Home Phone:(_____)_____ Work Phone: (_____)_____ Cell:(_____)_____

Soc. Sec. #: _____ Birth Date: ____/____/____ Drivers Lic. #: _____

E:Mail Address_____

Marital Status:(circle one) M S D W Sep Spouse Name: _____

Referred By:_____ Employer:_____

Occupation: _____

Family Physician: _____ Address: _____ Phone: _____

If your Primary or 2ndary Insurance is in Your Spouses Or Parent's Name, Please complete the following:

Parent's or Spouses Name_____ Date of Birth_____

Parent's or Spouses Place of Employment_____

Parent's or Spouses Address If Different From Above_____

Have you had other Chiropractic Treatment this year? Yes_____ No_____

If yes, how many visits?_____

Have you had X-rays in the last year? Yes_____ No_____ If yes, Where were they taken?

Name of Facility_____

SOCIAL HISTORY

Do you drink alcoholic beverages?_____ If so how much per week?_____

Do you use any tobacco products?_____ Do you smoke?_____ If so, packs per day:_____

Do you consume caffeine?_____ If so how much per day?_____

Do you exercise?_____ If yes, what frequency and type of exercise?_____

What are your hobbies?_____

Do you sleep well?_____ Sleeping posture? Side_____ Stomach_____ Back_____

Drugs, Including Prescription_____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother)

Tuberculosis_____ Cancer_____ Mental Illness_____

Diabetes_____ Kidney Disease_____ Lung Disease_____

Arthritis_____ Liver Disease_____

Stroke_____

Other_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Check any that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Broken of Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers |

Do you have a history of stroke or hypertension?

Have you been treated for any health condition by a physician in the last year? ____Yes ____No If yes, Describe

Have you had any major illnesses, injuries, falls auto accidents or surgeries?

WOMEN

Have you given birth ?..... Number of Children: Ages Of Children: to
Are you possibly pregnant? ____Yes ____No

Patient or Guardian Signature..... Date.....

Authorization and Assignment

It Is My Understanding That If I Become A Patient In This Office, I Agree To The Following:

Authorization To Release Information

I Am Authorizing You To Release Any Information You Feel Appropriate Concerning My Condition To Any Insurance Company, Attorney, Or Adjuster In Order To Receive Reimbursement On Any Charges Incurred By Me As A Result Of Services Rendered By You Professionally.

Authorization To Pay Directly To Doctor

I Authorize Direct Payment To You Of Any Sum That I Owe You Now Or In The Future From Any Insurance Company That Is Obligated To Reimburse Me For Charges Incurred In Your Office In Part Or Full/Or My Attorney Out Of The Proceeds Out Of My Settlement. A Photocopy Of This Form Is Acceptable For Payment.

Assignment of Cause Of Action

I Hereby Assign And Give To You, The Right To Take Action Against Any Insurance Company That Is Obligated By Contract To Make Payment To Me. I Authorize You To Take Action In Either My Name Or Your Name To Resolve This Claim. It Is Understood That All Reasonable Efforts Will Be Made To Collect From The Insurance Company Before I Will Be Responsible For This Bill. I Do Understand That Whatever Amounts Are Not Collected From The Insurance Company Do Become My Responsibility And I am Obligated To Pay These Charges As Soon As Possible.

Notice of Privacy Practices

This practice is required by federal law to maintain the privacy of your Patient Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Patient Health Information. Ashland Chiropractic Adheres to Ohio law in those instances where Ohio law does not conflict with federal law. We are required to abide by the terms of this Privacy Notice. We reserve the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your Patient Health Information that it maintains. We will distribute any revised Privacy Notice to you prior to implementation. We will not retaliate against you for filing a complaint. This Notice is in effect as of April 15, 2003.

I Understand That In The Event My Account Has To Be Turned Over To Collections, There Will Be A \$25.00 Collection Fee Added To My Account.

Patient or Guardian Signature_____Date_____

SUMMARY

1. What is your major symptom _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? ____ Yes ____ No ____ Same ____ Better
____ Gradually worse If yes, when and how? _____
4. How frequent is the condition? ____ Constant ____ Daily ____ Intermittent ____ Night Only
How long does it last? _____ All Day _____ Few Hours _____ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?
____ Yes ____ No. If yes, describe: _____
Are there other unrelated health problems? ____ Yes ____ No If yes, describe _____

6. Describe the pain: ____ Sharp ____ Dull ____ Numbness ____ Tingling ____ Aching
____ Burning ____ Stabbing ____ Other _____
7. Is there anything you can do to relieve the problem? ____ Yes ____ No. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? ____ Standing ____ Sitting ____ Lying ____ Bending
____ Lifting ____ Twisting ____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
____ Yes ____ No ____ Uncertain
11. Additional Remarks:

12. On a scale of 1 - 10 (10 being the worst pain), what is your pain level today? _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

+-----+

Place an "X" on the line above to indicate level of problem