REGISTRATION FORM

Please print clearly.

Today's Date: ____________________

PATIENT INFORMATION

Patient's Last Name First Middle Int.	☐ Ms. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.	☐ Single ☐ D.Prtnr ☐ Mar. ☐ Wid. ☐ Sep. ☐ Div.

Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) - ext	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address City State Zip	Personal E-mail:	Work E-mail:

Occupation	Employer	Employer Phone No. ( ) - ext.

The best place to contact me is (*circle one*): Home Work Cell Personal E-mail Work E-mail

How did you hear about us?
☐ Patient ______________________________ ☐ Dr. ______________________________ ☐ Insurance Plan ☐ Hospital
☐ Family Member/Friend ____________________ ☐ Internet ______ ☐ Close to home/work ☐ Other ________________

Primary Care Physician (PCP):	PCP Address:	PCP Phone: ( ) -

May we inform your PCP about your treatment? ☐ Yes ☐ No | Social Security Number _________-_______-__________

IN CASE OF AN EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Home Phone No. ( ) -	Work Phone No. ( ) -

PATIENT CONDITION

Unwanted condition (Why are you here today?)

Is your condition ☐ Auto Accident ☐ Job Related ☐ Home Injury Date of accident

How many times have you had these symptoms before?

☐ **Never** ☐ **1 – 2** ☐ **3 – 4** ☐ **5 – 7** ☐ **More than 7**

What activities and/or movements make your symptoms better or worse?
Better: Worse:

Are your symptoms:
☐ **Sharp** ☐ **Dull** ☐ **Burning** ☐ **Tingling** ☐ **Numb** ☐ **Shooting Pain** **Where? ___________________________**

☐ **Cramps** ☐ **Stiffness** ☐ **Swelling** ☐ **Throbbing** ☐ **Other: ____**

How bad are your symptoms? 0 = no pain 10 = unbearable pain

At their worst: 1 2 3 4 5 6 7 8 9 10 At their best: 1 2 3 4 5 6 7 8 9 10

How much of the day do you experience your symptoms?

☐ **(76 – 100%)** ☐ **(51 – 75%)** ☐ **(26 – 50%)** ☐ **(0 – 25%)**

What time of the day is the pain at its worst?

☐ **Morning, on arising** ☐ **Late in the morning** ☐ **Afternoon** ☐ **Evening**

☐ **Bedtime** ☐ **Night (disturbs sleep)** ☐ **Pain is always the same** ☐ **Pain varies, no particular time.**

How do your symptoms affect your ability to perform your daily activities?

☐ **No effect** ☐ **Mild, forgotten with activity** ☐ **Moderate, interferes with activity** ☐ **Limiting, prevents full activity**

☐ **Intense, always seeking relief** ☐ **No activity possible**

Have you received treatment for the same condition in the past? ☐ **Yes** ☐ **No**
If "yes," what type of treatment did you receive? ☐ **Chiropractic care** ☐ **Other: ___________________________________**
What tests, if any, were performed? ☐ **X-Ray(Date) ________** ☐ **MRI(Date) ________** ☐ **CT(Date) __________**
Were you satisfied with the results? ☐ **Yes** ☐ **No**

PATIENT HISTORY

Previous Auto Accidents or Trauma?

Injuries/Surgeries you have had:

Description Date(s)

Falls: ____

Head Injuries: ____

Broken Bones: ____

Dislocations: ____

Surgeries: ____

Habits:

☐ Tobacco: ☐Smoker_____ pack(s)/day for ____ year(s)

☐Live with Smoker

☐ Alcohol: _____ drinks per week

☐ Caffeine Drinks: _____ cups per day

☐ High Stress Level: Reason: ____________________

Exercise level within the last 6 months?

☐ None **Type:**

☐ 1-2 times per week

☐ 3-5 times per week

☐ Daily

Constitutional ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Chills ☐ Weight Gain ☐ Daytime Drowsiness ☐ Weight Loss ☐ Fatigue ☐ Fever ☐ Night Sweats

Eyes/Vision ☐ I deny any of the symptoms or problems listed below ☐other

☐ Blindness ☐ Blurred Vision ☐ Cataracts ☐ Change of Vision ☐ Double Vision ☐ Eye Pain ☐ Field Cuts ☐ Glaucoma ☐ Itching ☐ Photophobia ☐ Tearing ☐ Glasses ☐ Contact lenses

Ears, Nose, and Throat ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Bleeding ☐ Dentures ☐ Difficulty Swallowing ☐ Discharge ☐ Dizziness ☐ Ear Drainage ☐ Ear Pain ☐ Fainting ☐ Frequent sore throats ☐ Headaches ☐ Hearing loss ☐ History of head injury ☐ Hoarseness ☐ Loss of sense of smell ☐ Nasal congestion ☐ Nosebleeds ☐ Postnasal Drip ☐ Runny nose ☐ Sinus infections ☐ Snoring ☐ Sore thoat ☐ Ringing in the ears ☐ TMJ problems

Respiration ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Asthma ☐ Cough ☐ Coughing up blood ☐ Shortness of breath ☐ Sputum production ☐ Wheezing

Cardiovascular ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Angina ☐ Chest Pain ☐ Claudication ☐ Heart Murmur ☐ Heart Problem ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Difficulty breathing lying down ☐ Palpitations ☐ Ulcers ☐ Shortness of breath with exercise ☐ Swelling of legs

Gastrointestinal ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Abdominal Pain ☐ Belching ☐ Black tarry stools ☐ Constipation ☐ Diarrhea ☐ Difficulty swallowing ☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Jaundice ☐ Nausea ☐ Rectal bleeding ☐ Abnormal stool color /caliber /consistency ☐ Vomiting ☐ Vomiting Blood

Female ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Birth Control ☐ Breast Lumps ☐ Burning Urination ☐ Cramps ☐ Frequent Urination ☐ Hormone Therapy ☐ Irregular menstruation ☐ Pregnancy ☐ Urine Retention ☐ Vaginal Bleeding ☐ Vaginal Discharge ☐ Vaginal Pain

Male ☐ I deny any of the symptoms or problems listed below ☐ other Date of Late Prostate Exam_____________

☐ Burning Urination ☐ Erectile Dysfunction ☐ Frequent Urination ☐ Dribbling ☐ Prostate Problems ☐ Urine retention

Endocrine ☐ I deny any of the symptoms or problems listed below ☐ other

☐Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive hunger ☐ Excessive Thirst ☐ Abnormal frequency of unrination ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair growth ☐ Voice Changes

Skin ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Changes in nail texture ☐ Changes in skin color ☐ Hair Growth ☐ Hair Loss ☐ Hives ☐ History of Skin disorders ☐ Itching ☐ Paresthesia ☐ Rash ☐ Skin Lesions ☐ Ulcers ☐ Varicosities

Nervous system ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of consciousness ☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep disturbances ☐ Slurred speech ☐ Stress ☐ Strokes ☐ Tremor ☐ Unsteady Gait ☐ Loss of Balance

Psychologic ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Anhedonia ☐ Anxiety ☐ Change in appetite ☐ Behavioral Change ☐ BiPolar Disorder ☐ Confusion ☐ Convulsions ☐ Depression ☐ Insomnia ☐ Memory Loss ☐ Mood Change

Allergy ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Anaphalaxis ☐ Food intolerance ☐ Itching ☐ Nasal Congestion ☐ Rash ☐ Sneezing

Hematologic ☐ I deny any of the symptoms or problems listed below ☐ other

☐ Anemia ☐ Bleeding ☐ Blood Clotting ☐ Blood transfusion ☐ Bruising easily ☐ Fatigue ☐ Lymph Node Swelling

Have you been diagnosed or been told you have any of the following? (*Please check all that apply*)

- ☐ AIDS/HIV; date ___________________
- ☐ Cancer: _________________________
- ☐ Headaches
- ☐ Organ Disease: ___________________
- ☐ Heart condition: _________________
- ☐ Diabetes: Type I or Type II
- ☐ Osteoporosis
- ☐ Hardening of the arteries
- ☐ Epilepsy
- ☐ Eating Disorder: __________________
- ☐ Neurologic Disease: ______________
- ☐ Heart or blood vessel disease
- ☐ Bone spurs
- ☐ Blood in stool/urine
- ☐ Anemia
- ☐ Herniated disc: __________________
- ☐ Hypertension
- ☐ Stroke
- ☐ Whiplash
- ☐ Pacemaker
- ☐ Blurred vision/Double vision
- ☐ Tumors or Growths: _____________
- ☐ Psychiatric Care: ________________
- ☐ Addictions: ____________________
- ☐ Sexually Transmitted Disease: _____
- ☐ Other: ________________________ ____________________________

Have you had any of the following symptoms for even a short period during the past year? (*Please check all that apply*)

- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Hearing Loss
- ☐ Loss of bowel/bladder control
- ☐ Abdominal pain/pulsations
- ☐ Difficulty swallowing
- ☐ Slurred speech or other speech problems
- ☐ Persistent cough
- ☐ Diminished or partial loss of vision
- ☐ Temporary lack of understanding
- ☐ Numbness or loss of sensation in the face, arms, hands, fingers or legs
- ☐ Any other abnormal or loss of sensation in another body part
- ☐ Weakness, clumsiness or strength loss in the face, arms, hands, fingers or legs
- ☐ Unexplained weight loss
- ☐ Loss of consciousness
- ☐ Sudden collapse without loss of consciousness
- ☐ Other: ____

Are you under a doctor's care presently for any type of health problem? ☐ Yes ☐ No
If "yes," please explain: ____

What, if any, diseases run in your family?

Have any relatives ever suffered a stroke? ☐ Yes ☐ No If "yes," who? ______________________________

Please list any allergies:

Please list any Medications your are currently taking:

Please list Vitamins/Supplements you are currently taking:

WOMEN ONLY

Do you take birth control pills? ☐ Yes ☐ No If "yes," how long? ____________ Date of last period: ____________	Do you experience any of the following: ☐ Menstrual pain ☐ Cramping ☐ Irregularity ☐ History of vaginal infections	Are you pregnant? ☐ Yes ☐ No If "yes," due date: _______________ # of Births: _______ Type: _______

FINANCIAL POLICY, RELEASES, AND AUTHORIZATION FOR TREATMENT

I understand and agree that health and accident health insurance policies are agreements between my insurance carrier and me. Furthermore, I understand that Dr. Deppen will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Deppen will be credited to my account upon receipt. How, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that any unpaid amount if not paid within 60 days of termination of care, may be sent to collections and all court, attorney and collection fees are my responsibility.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that I, as the patient, am responsible for all bills incurred at this office. Payment plans are at the sole discretion of Dr. Deppen and prior arrangements must be made before services are rendered.

Patient/Guardian Signature: ____ Date: ___________

INSURANCE POLICY INFORMATION

Who will be responsible for your bill?

☐ BlueCross/BlueShield PPO ☐ Medicare – Part B ☐ Workers Comp ☐ Auto Insurance
☐ Myself Only ☐ Spouse ☐ Out of Network PPO______________________

Please allow us to make a copy of your insurance card and identification for your file. We will be happy to verify your chiropractic coverage in this office.

Primary Insured: ____
(Last Name) (First Name) (Middle Initial)

Primary Insured's Date of Birth: _____________________

Member ID #_____________________________________ Group #___________________________

(For Auto/Workers Comp only)
Claim #____________________________________ Carrier____________________________
Policy #____________________________

Adjuster: ___________________________________ Carriers Phone #____________________

How will you pay for today's visit? ☐ Cash ☐ Check

GOALS AND EXPECTATIONS

I want my pain to be reduced to:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

I want to be able to: ____

I think this can be accomplished in: ☐ one week ☐ one month ☐ two months ☐ six months

In addition to chiropractic care, I think I will need:

☐ Rehabilitative Exercises ☐ Massage Therapy ☐ Nutrition Counseling ☐ Supplements
☐ Physical Therapy ☐ More Diagnostic Testing ☐ Medicines ☐ Surgery

We, the doctor and staff, will do our best to find the cause(s) of your condition and educate you about your body and our findings in terms you will understand. It is our job to provide you with the best care possible and it is your job to decide whether or not you want it. We want you to be so satisfied with our treatment and services that you will eagerly refer others to us for care.

Thank you for choosing us!

Privacy Notice

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPPA notice in our procedures manual.

1. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the privacy notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to signing the consent, and has encouraged me to read the privacy notice prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in this privacy notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcare mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine; and c) emailing me at the address provided by me.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. I understand that I have a right to request that the practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care requested. If the practice agrees to a requested restriction, then the restriction is binding on the practice.
6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
7. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. The practice has taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
8. I understand I have a right to file a formal complaint with the privacy official about any possible violations of these policies and procedures.
9. I understand if I am referred by an individual, the Practice may mail a postcare or send a letter to the individual acknowledging the referred. Only my name will be used. No other PHI will be given.
10. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.
11. I understand that if I do not sign the consent evidencing my consent to the uses and disclosures described to me above, and contained in the privacy notice, then the practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_______________________________________ x____

Name of Individual (Printed) Signature

____

Parent signature of Minor

Date____/____/_____