

Advanced Care Chiropractic REGISTRATION

Date _____

Patient _____ Home Phone _____
Last Name First Name Middle Initial

Street Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Single Married Widowed Separated Divorced # of children _____

Social Security # _____ Driver's License # _____ Religion (optional) _____

Condition Related to: Auto Accident Work-related Injury Other Injury Illness Unknown

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
SPOUSE	Name _____ <small style="margin-left: 100px;">Last Name</small> <small style="margin-left: 150px;">First Name</small> <small style="margin-left: 150px;">Middle Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____
INSURANCE INFORMATION	Health Insurance (if you have card, please give it to receptionist to make copy) Insurance _____ Insured's Name _____ Group # _____ ID# _____
MEDICAL AND LEGAL INFORMATION	Family Physician _____ Phone _____ Attorney (if auto or work-related) _____ Phone _____ Known Medical Problems _____ _____ Person to contact in emergency (Name & Phone #) _____ _____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Advanced Care Chiropractic all medical benefits otherwise payable for services. I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of this signature on all my insurance submissions and to obtain records. _____ <div style="display: flex; justify-content: space-between;"> Signature of Insured/Guardian Date </div>

How did you learn of our practice? Yellow Pages Personal referral Drive by/Sign Other

If you were referred, whom may we thank? _____

FINANCIAL POLICY

Payment is requested for all office services at the time rendered and may be paid by cash or check. Payment on the day of service is eligible for a cash discount. If you have insurance that pays for chiropractic, we will be glad to bill for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements, please talk to the office manager.

Advanced Care Chiropractic

Brian L. Vroom, DC, DAAPM

Michelle Waggoner, DC

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature _____

Date _____

STOP HERE

Portion Below Used If Additional Information Requested & Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

Signature _____

Date _____

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Occupation _____

EMPLOYER

Employer Name _____ Telephone _____
Address _____
Contact Person _____ Notified Employer? Y N Witness _____

INJURY INFORMATION

Date of Injury _____ Time of Injury _____

Place of Injury _____

Give full description of how accident happened (equipment involved, condition of area, etc.)

Where did you feel pain or unusual symptoms after the accident? Describe and give location/body part injured

Have you lost time from work because of this injury? Y N Describe _____

Have you returned to work? Y N Are work activities restricted because of this accident? Y N

Job description (e.g. lifting requirements, repetitive use of hands, etc.) _____

Did you leave work area after accident? Y N Did you seek medical attention? Y N

Did you consult another doctor? Y N Name _____ Xrays taken? Y N

Diagnosis and treatment given _____

Form 827 filled out? Y N Form 801 filled out at work? Y N

Have you injured this area before? Y N When? _____ Did you file a work comp claim? Y N

Any other previous Worker Compensation injuries? Y N When? _____

Describe previous Work Comp injuries _____

Patient's Signature

Date