

# Advanced Care Chiropractic REGISTRATION

Date \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name
First Name
Middle Initial
Home Phone \_\_\_\_\_

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

<b>EMPLOYER</b>	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
<b>SPOUSE</b>	Name _____ <small style="display: inline-block; width: 20%; text-align: center;">Last Name</small> <small style="display: inline-block; width: 20%; text-align: center;">First Name</small> <small style="display: inline-block; width: 20%; text-align: center;">Middle Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____
<b>INSURANCE INFORMATION</b>	<b>Health Insurance (if you have card, please give it to receptionist to make copy)</b> Insurance _____ Insured's Name _____ Group # _____ ID# _____
<b>MEDICAL AND LEGAL INFORMATION</b>	Family Physician _____ Phone _____ Attorney (if auto or work-related) _____ Phone _____ Known Medical Problems _____ _____ Person to contact in emergency (Name & Phone #) _____ _____
<b>PATIENT AGREEMENT</b>	<b>ASSIGNMENT AND RELEASE</b> 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;"> <span>Signature of Insured/Guardian</span> <span>Date</span> </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**

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## 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 \_\_\_\_\_

# Advanced Care Chiropractic

## Confidential Health Questionnaire

Date \_\_\_\_\_

Note: **PLEASE ANSWER EVERY QUESTION.** If something does not apply to you, put "NA". If you need help filling out this form please ask the receptionist.

Patient name \_\_\_\_\_ Birthdate \_\_\_\_\_

Chief complaint (describe symptoms, **include location**) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_  Gradual onset or  sudden onset of symptoms?

Is it getting progressively worse?  Yes  No  Unknown

Is it:  constant  comes and goes \_\_\_\_\_ Does it interfere with:  Work  Sleep  Daily routine  Recreation

Activities or movements that are painful to perform:  Sitting  Walking  Bending  Lying down  Other \_\_\_\_\_

Have you been treated for this problem before?  No  Yes If yes, by who? \_\_\_\_\_

What did they do/recommend? \_\_\_\_\_

Are there any other areas of complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Occupation \_\_\_\_\_

(Describe activities - sitting, lifting, etc.)

Have you ever had chiropractic care for other problems?  No  Yes When and for what? \_\_\_\_\_

Date of last: Physical exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ Breast exam/mammogram(women) \_\_\_\_\_ Prostate exam (men) \_\_\_\_\_

Hospitalizations/Surgeries? (list cause and dates) \_\_\_\_\_

Have you had any serious illnesses? (list and date) \_\_\_\_\_

Have you been involved in any auto (or other) accidents in the past? (briefly describe and date) \_\_\_\_\_  
\_\_\_\_\_

Have you:  Had a broken bone?  Been treated for spinal or nerve disorder?  Had an implant/pacemaker?

Do you exercise regularly (non-job)?  No  Yes How often and type of exercise \_\_\_\_\_

Sleep \_\_\_\_\_ hrs/night. Restful?  No  Yes Do you sleep on your:  Back  Side  Stomach

Do you smoke?  No  Yes How much? \_\_\_\_\_ Do you drink?  No  Yes How much? \_\_\_\_\_ per day/week

(Women Only) Are you pregnant?  No  Yes Date of last menstrual period \_\_\_\_\_

Do you take  Muscle relaxers  Painkillers  Insulin  Birth control pills  Over-the-counter medications  Other prescription drugs

**MEDICATION** List all medications you are currently taking

**VITAMINS/MINERALS/HERBALS**

MEDICATION List all medications you are currently taking	VITAMINS/MINERALS/HERBALS

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date