Chiropractic Registration & History

< PATIENT INFORMATION >

Date ______
Patient (Last Name) ______
Name (First Name) ______
Address ______
City ______
State ______ Zip code ______
Email ______
Sex M F O
Age ______ Birthdate ______
Marital Status
Single Married Minor
Other ______
Spouse's Name ______
Spouse's Birthdate ______

< PHONE NUMBERS >

Home Phone ______
Cell Phone ______
Best time to reach you ______

In Case of Emergency, Contact
Name ______
Relationship ______
Cell Phone ______
Work Phone ______

< OTHER INFORMATION >

Occupation/ School ______
Occupation/ School Phone ______
Occupation/ School Address ______

< HOW DID YOU FIND OUT ABOUT OUR OFFICE? >

Ads Web Searching Referral - Whom may we thank for referring you? : ______ Other

< PATIENT CONDITION >

- Reason for Visit ______
- When did your symptoms appear? ______
- Is this condition getting progressively worse?

Yes No Unknown

- Mark an "X" on the picture where you continue to have pain and symptoms
- Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever pain) ______
- Type of Pain

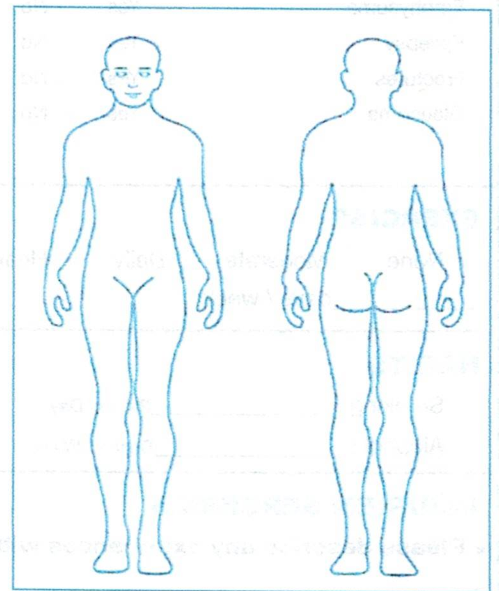
Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramping Stiffness
Swelling Other ______

- Is it constant or does it come and go? ______
- Does it interfere with your

Work Sleep Daily Routine Recreation Other

- Activities or movements that are painful to perform

Sitting Standing Walking Bending Lying Down



Patient Consent For Use & Disclosure Of Protected Health Information
Chico Upper Cervical Health Center 852 Manzanita Ct., Ste. 150 Chico, Ca 95926

With my consent, Chico Upper Cervical Health Centers may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Health Center Notice of Privacy for a more complete description of such uses and discloser.

I have the right to review the Notice of Privacy prior to signing this consent. Chico Upper Cervical Health Center reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy may be obtained by forwarding a written request to Upper Cervical Health Center.

With my consent, Chico Upper Cervical Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist in the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Chico Upper Cervical Health Center may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements.

By signing this form, I am consenting to Chico Upper Cervical Health Center use and disclosure of my PHI to carry out TPO.

I MAY revoke my consent in writing except that the practice already has made disclosure in reliance upon my prior consent. If I do not sign this consent, Chico Upper Cervical Health Centers may decline to provide me treatment to me.

______________________________ Signature of Patient or Legal Guardian

______________________________ Print Name of Patient or Legal Guardian

Authorization to Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

______________________________ Signature

______________________________ Date

Authorization to Pay/Release is Granted to:

Kelly W. Baker DC
852 Manzanita Ct., Ste. 150
Chico, Ca 95926

< HEALTH HISTORY >

- **What treatment have you already received for your condition?**

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ Other ____________ ☐ None

- **Name and address of other doctor(s) who have treated you for your condition**

____

- **Date of Last:**

☐ Physical Exam __________ ☐ Spinal X-ray __________ ☐ Blood Test __________
☐ Spinal Exam __________ ☐ Chest X-ray __________ ☐ Urine Test __________
☐ Dental X-ray __________ ☐ MRI, CT scan, Bone Scan __________ ☐ Other __________

- **Place a mark on "Yes" or "No" to indicate if you have had any of the following:**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	Yes	No	Goiter	Yes	No	Pneumonia	Yes	No
Alcoholism	Yes	No	Gonorrhea	Yes	No	Polio	Yes	No
Allergy	Yes	No	Gout	Yes	No	Prostate Problem	Yes	No
Anemia	Yes	No	Heart Disease	Yes	No	Prosthesis	Yes	No
Anorexia	Yes	No	Hepatitis	Yes	No	Psychiatric Care	Yes	No
Appendicitis	Yes	No	Hernia	Yes	No	Rheumatoid Arthritis	Yes	No
Arthritis	Yes	No	Herniated Disk	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Bleeding Disorder	Yes	No	High Cholesterol	Yes	No	Stroke	Yes	No
Breast Lump	Yes	No	Kidney Disease	Yes	No	Suicide Attempt	Yes	No
Bronchitis	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Bulimia	Yes	No	Measles	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Migraine Headaches	Yes	No	Tuberculosis	Yes	No
Cataracts	Yes	No	Miscarriage	Yes	No	Tumor, Growth	Yes	No
Chemical Dependency	Yes	No	Mononucleosis	Yes	No	Typhoid Fever	Yes	No
Chicken Pox	Yes	No	Multiple Sclerosis	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Mumps	Yes	No	Vaginal Infections	Yes	No
Emphysema	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No	Whooping Cough	Yes	No
Fractures	Yes	No	Parkinson's disease	Yes	No	Other __________		
Glaucoma	Yes	No	Pinched Nerve	Yes	No	__________		

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

__________days / week

WORK ACTIVITY

☐ Light Labor ☐ Standing
☐ Heavy Labor ☐ Sitting

PREGNANCY

☐ Pregnant ☐ No
* Due Date: __________

HABITS

☐ Smoking : __________Packs / Day ☐ Coffee/Caffein Drinks : __________Cups / Day
☐ Alcohol : __________Drinks / Week ☐ High Stress Level : Reason __________

INJURIES/ SERGERIES

- **Please describe any experiences with falls, head injuries, bone fractures, dislocations, or surgeries.**

- ______________________________________ Date __________
- ______________________________________ Date __________

MEDICATIONS

____
____
(Pharmacy Name/ Phone)

ALLERGIES

____
____

VITAMINS/ HERBS/ MINERALS

____
____

Financial Office Policy

Chico Upper Cervical Health Center 852 Manzanita Ct., Ste. 150 Chico, Ca 95926

1. All patients are on cash basis until their respective insurance coverage and deductible are verified by our staff.
2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. After coverage and deductible are verified, this office may accept assignment on most policies provided the insurance/patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).
5. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient it is your responsibility to take care of the co-payment and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making decisions about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.
8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
9. This office will resubmit a claim one time. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. All insurance payments, regardless of which company issues a check, first, are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.
11. If you receive any correspondence or checks from your insurance company, you agree to bring these to our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
12. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
13. If you change insurance companies or employers, you agree to provide this office with current information immediately.
14. This office accepts, MasterCard, Visa, Cash and personal checks.
15. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department.

I have read and understand the financial office policy and agree to abide by these terms.

____________________________ ________________________

Patient Signature Date