CHIROPRACTIC PATIENT REGISTRATION AND HISTORY

Today's Date: _____/_____/_____ Date Symptoms began: _____/_____/_____

Is your condition due to an accident? ◯ Yes ◯ No Type: ◯ Auto ◯ Work ◯ Home ◯ Other

Name : _____
Last First Middle

Address: _____
Street City State Zip

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Sex: ◯ Male ◯ Female Current Age:_____ How did you hear about us? _____

◯ Married ◯ Single ◯ Widow(er) ◯ Divorced ◯ Minor

Permanent Mailing Address (if different): _____
Street City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____ Preferred number Cell_____ Work _____ Home_

How would you prefer your appointment reminders? ◯ Text Message ◯ Email

Cellular Provider: ◯ AT&T ◯ SPRINT ◯ T-MOBILE ◯ US CELLULAR ◯ VERIZON ◯ Other _____

Email Address (please print clearly) _____@ _____. _____
___

I**n Case Of Emergency, Contact**: _____
Last First Middle

Relationship to Patient: _____

Contact #: _____

Please list anyone that you will allow us to discuss your account with _____

Name of Employer:_____Phone: (_____)_____

PCP Name: _____ PCP Phone: _____

PCP Address: _____

May we contact your PCP to advise them of your progress? _____

PATIENT CONDITION AND HEALTH HISTORY

1. Symptoms Experienced: _____

2. What treatment have you already received for your condition?

◯ Medication ◯ Chiropractic Care ◯ Surgery ◯ Physical Therapy ◯ None ◯ Other ___

Was it a positive experience? _____

3. When did your symptoms begin: _____/ _____/ _____Is this condition progressively worse: ◯ Yes ◯ No

4. How often do you have these symptoms? _____

5. Rate the Pain – (0 is pain free – 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

6. Are the symptoms constant or do they come and go? _____

7. What does the pain feel like?
Sharp, Dull, Achy, Stabbing, Throbbing, Burning, Numb, Tingling, Weakness, Shooting, Radiating, Other _____

8. Do these symptoms interfere with your ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

9. What activity are you unable to do at 100% that you miss the most? _____

10. Which of the following are painful to perform: ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lying Down

Indicate Yes or No if you have/had any of the following-Mark box for Self or Family:

Allergy Shots	◯ Self	◯ Family	Arthritis	◯ Self	◯ Family	Pinched Nerve(s)	◯ Self	◯ Family
Epilepsy	◯ Self	◯ Family	Stroke	◯ Self	◯ Family	Rheumatoid Arthritis	◯ Self	◯ Family
Cancer	◯ Self	◯ Family	Fractures	◯ Self	◯ Family	Migraine Headaches	◯ Self	◯ Family
Gout	◯ Self	◯ Family	Asthma	◯ Self	◯ Family	Multiple Sclerosis	◯ Self	◯ Family
Osteoporosis	◯ Self	◯ Family	Diabetes	◯ Self	◯ Family	Tumors or Growths	◯ Self	◯ Family
Chemical Dependency	◯ Self	◯ Family				Heart Disease	◯ Self	◯ Family

Communicable Disease / Blood Born Illness ◯ Self ◯ Family

Any condition with your eyes? ◯ Yes ◯ No Explain: _____

Any condition with your ears, nose or throat? ◯ Yes ◯ No Explain: _____

Are you pregnant? ◯ Yes ◯ No

Injuries/Surgeries you have had: Description Date

_____

_____

_____

List any current MEDICATIONS, VITAMINS, HERBS, MINERALS that you are taking: _____

Allergies ◯ Yes ◯ No Describe: _____

Exercise: ◯ None ◯ Moderate ◯ Daily ◯ Heavy

Habits: ◯ Smoking Packs/Day _____ ◯ Alcohol Drinks/Week _____

◯ Coffee/Caffiene Drinks Cups/Day _____

Stress Level ◯ 1-3 ◯ 4-7 ◯ 8-10 Reason _____

Work Activity: ◯ Sitting ◯ Standing ◯ Light Labor ◯ Heavy Labor

Describe your work activities/duties: _____

Patient or Authorized Person's Signature: I affirm the above information is accurate to the best of my knowledge.

Signed: _____ Date: _____/ _____/ _____

INSURANCE AND PAYMENT INFORMATION

Person responsible for this account: _____

Relationship to Patient: _____

Primary Insurance Company _____

Subscribers Name: _____ Subscribers Social Security # _____- _____- _____

Group # _____ Relationship to Patient: _____

Insured's Address: _____
Street City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Is Patient covered by secondary or additional insurance? ◯ Yes ◯ No

Secondary Insurance Company_____

Subscribers Name: _____ Subscribers Social Security # _____- _____- _____

Group # _____ Relationship to Patient: _____

Patient or Authorized Person's Signature: I authorize Active Care Chiropractic to release any medical information, diagnosis and the records of any treatment or examination rendered to me in order to process my insurance claim.

Signed: _____ Date: _____/ _____/ _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Active Care Chiropractic for services rendered.

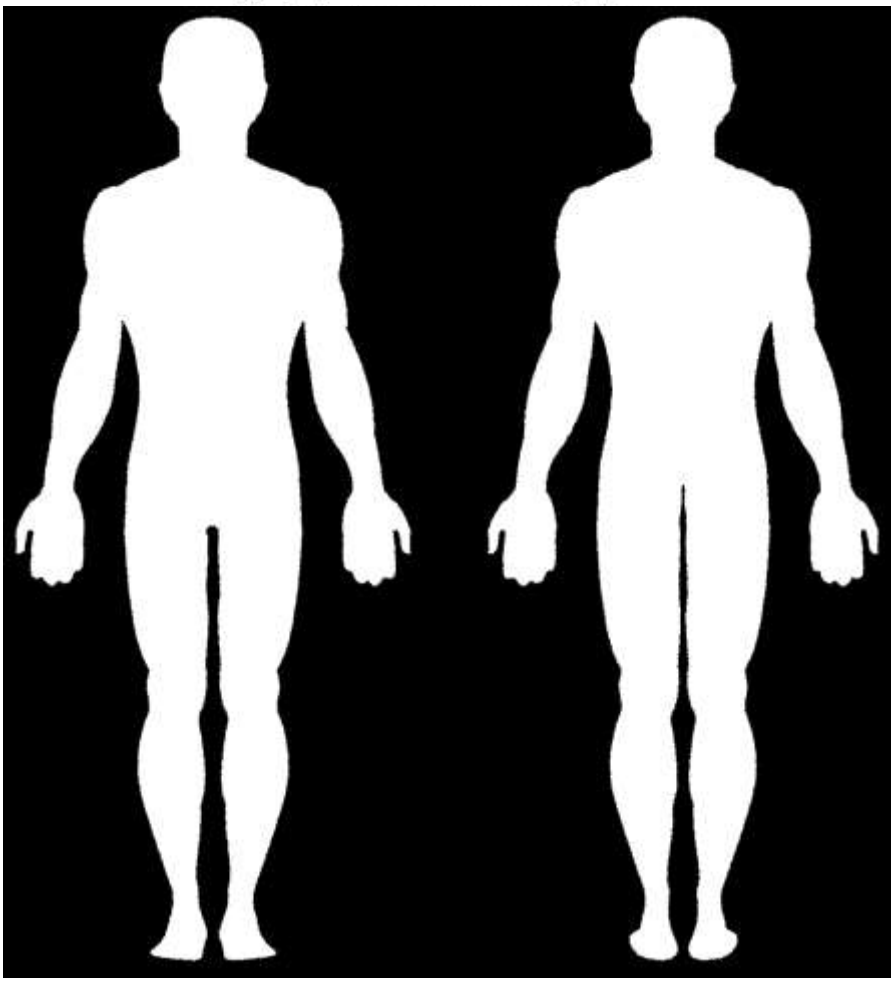
I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at Active Care Chiropractic.

I also understand that all co-pays, co-insurances, and deductibles (not already met) are due at the time service is rendered.

Signed: _____ Date: _____/ _____/ _____

Name: _____ Date: _____ / _____ / _____

[ ] Dr. Jason Block
[ ] Dr. Tyler Comer
[ ] Dr. Charlie Brickman
[ ] Dr. Jesse Valadez



FRONT BACK

Indicate all areas where you experience the following:

X - Pain

/ - Tingling

0 - Tension

* - Numbness

Using index on the reverse side indicate **today's** pain level with a circle and please mark the pain levels at their worst with a triangle.

	Example	0 - 1 - 2 - (3) - 4 - 5 - △6 - 7 - 8 - 9 - 10
1.	Neck	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
2.	Upper Back	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
3.	Mid Back	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
4.	Lower Back	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
5.	Headaches	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
6.	TMJ	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
7.	Shoulders	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
8.	Arms/Elbows	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
9.	Knees	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
10.	Legs/Ankle	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
11.	Other _____	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Pain Index

_____

Everyone at Active Care is here to improve your health and way of life.

Patient Health Information Consent Form

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 Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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. We have 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact our Doctor at (405)-478-1507

Active Care Chiropractic Financial Agreement

Dear Patient:

Active Care Chiropractic will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Active Care Chiropractic. We wish to make it very clear that your health is your sole responsibility. These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended.

I choose the following method of payment for my care at Active Care Chiropractic:

_____ **CASH** - Payment is due at the time of services. All patients who wish to file their own insurance may receive the same cash price by paying for the service at the time of the service and waiting for reimbursement from their insurance company.
_____ **MEDICARE** - Payment for co-pays and deductibles is due at time of service.
_____ **WORKERS COMPENSATION** - My employer has agreed to pay for the services rendered by Active Care Chiropractic. I understand that I am responsible for any portion of this bill that my employer or their insurance carriers may refuse to pay.
_____**PERSONAL INJURY** – We will file your claim with the appropriate insurance carrier (**your** health insurance and/or auto med-pay), and the third party carrier (other person's insurance) as you are treated and file a Physician's Lien to assure payment. The third party carrier will usually not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree **not** to allow your attorney to reduce our fees for their/your profit. When released, a 90 day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/terminated care without your doctor's approval, the balance of your account is due immediately.
_____**INSURANCE POLICY COVERAGE** – Group insurance is an agreement between you and your insurance company, not between your insurance company and your doctor. As a courtesy to our patients, our office will complete and file your claims on standard forms at no charge. We are credentialed as In-Network providers by most insurance plans. The amount they pay varies from one policy to another. Because of the difference between policies, we request that each patient pay the deductible, percentage, and/or co-pay as stated in your policy.
_____**CARE CREDIT –** Upon approval from care credit, I will pay for each visit using the care credit card or in advance for a series of treatments.

Responsible Party Name (*print)*

_____Date:_____

Responsible Party Name (sign)

_____

3201 E. Memorial Rd, Suite B, Edmond, OK 73013
1405 S. Douglas Blvd., Suite E. Midwest City, OK 73130
(405)478-1507

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept them for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTIC OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____

(signature) (date)