Maximum Potential Chiropractic Registration and History

Patient Information

Social Security # _____

Last Name_____

First Name_____

Address_____

City/State/Zip_____

Email_____

Cell Phone_____Home Phone_____

Please indicate which # personal health information maybe left on a message _____

Sex [ ]M [ ]F Age_____ Birth date_____

[ ] Married [ ] Widowed [ ] Single [ ] Divorced

Employer_____

Employer Address/Phone_____

Occupation_____

Spouses Name_____ DOB_____

Spouses Employer_____

Whom may we thank for referring you?_____

Primary Care Physican?_____

Address/Phone_____

Insurance Assignment and Release

Primary Insurance_____

Policy Holder Name_____

Relationship to Patient [ ]Self [ ]Child [ ] Spouse

ID#_____ Group#_____

Birth date_____ SS#_____

Secondary Insurance_____

Policy Holder Name_____

Relationship to Patient [ ]Self [ ]Child [ ] Spouse

ID#_____ Group#_____

Birth date_____ SS#_____

I certify that I, and/or my dependent(s), have coverage with the Insurance company listed above and assign directly to Maximum Potential Chiropractic, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named entity may share my health information with the above named Insurance Company(ies) for the purpose of obtaining payment and determining benefits for related services. I also understand I will be billed $20-35 for missed massage appointments when I do not provide 24hrs notice.

X_____

As a courtesy, we will verify your benefits. We highly encourage you to double-check your benefits as we are often misquoted by customer service representatives.

X_____

Person to contact in case of emergency (Name and Phone)_____

Have you ever been under Chiropractic Care? Y N If so, Who?_____

What is your goal in our office?_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Maximum Potential Chiropractic,** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature_____ Date_____

Health History

Is the condition due to an accident? [ ]Yes [ ]No Date:_____ Type? [ ]Auto [ ]Work [ ]Home [ ]Other

To whom have you made a report? [ ]Auto Insurance [ ]Employer [ ]Workers Comp [ ]Other

Claim Number _____Ins Phone Number_____ Attorney Name_____

Have you received any of the following treatments for your condition?

[ ] Medication [ ] Surgery [ ]Physical Therapy [ ] Chiropractic [ ] None [ ]Other:_____

Name and Address of other doctor(s) who have treated 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 _____

Please Circle to indicate if you have had any of the following:

AIDS/HIV	Hepatitis	Pinched Nerve
Appendicitis	Hernia	Pneumonia
Arthritis	Herniated Disc	Polio
Asthma	Herpes	Prosthesis
Bleeding Disorders	High Cholesterol	Psychiatric Care
Bronchitis	Kidney Disease	Rheumatoid Arthritis
Cancer	Liver Disease	Stroke
Diabetes	Migraines	Thyroid Problems
Emphysema	Miscarriage	Tonsillitis
Epilepsy	Multiple Sclerosis	Tuberculosis
Fractures	Osteoporosis	Tumors, Growths
Gout	Pacemaker	Typhoid Fever
Heart Disease	Parkinson's	Ulcers
		Metal, Mechanical, Electrical Implants
		Other:

Family History please check all that apply:

□Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke □ Rheumatoid Arthritis

□Other_____

Social History please check all that apply:

Exercise

[ ]None [ ]Moderate

[ ]Light [ ]Heavy

Work Activity

[ ]Sitting [ ]Standing

[ ]Light Labor [ ]Heavy Labor

Habits

[ ]Smoking Packs/Day___

[ ]Alcohol Drinks/Week___

[ ]Coffee/Caffeine Cups/Day____

Are you pregnant? [ ]Yes [ ]No Due Date_____

Head Injuries _____

Broken Bones/Dislocations _____

Illness/Disease _____

Surgeries _____

Other _____

Medications	Allergies	Vitamins/Herbs/Minerals

Maximum Potential Chiropractic
155 Northland Dr, Medina, OH 44256
(330) 723-1441 (p) ~ (330) 723-1881 (f)

Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Maximum Potential Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $20 - $35

Consent to Evaluate and Treat a Minor:

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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____