



# Chiropractic Registration and History For Wayne Sport & Spine Center, LLC.

Date: \_\_\_\_\_

# 1

## Patient Information

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

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

Email \_\_\_\_\_

Sex: Male  Female

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_

Married  Widowed  Single  Minor

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

# 2

## Phone Numbers

Home Phone \_\_\_\_\_

Cell \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

# 3

## Insurance Information

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_

Is patient covered by additional insurance? Yes  No

# 4

## Current Health Condition

Have you seen other doctors for this condition?

Yes  No  Who? \_\_\_\_\_

Type of Treatment \_\_\_\_\_

Results \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Has this condition occurred before? Yes  No

Drugs you now take: \_\_\_\_\_

Is there a family history of this condition? Yes  No

Do you currently use tobacco? Yes  No

Do you suffer from a condition not related to your visit here today? \_\_\_\_\_

# 5

## Accident Information

Is this condition due to an accident? Yes  No

Date of accident \_\_\_\_\_

Type of Accident: Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Workers Comp.

Other

Attorney Name (if applicable) \_\_\_\_\_

# 6

## Past Health History

Please check or describe:

Major surgery/ operations: Appendectomy

Tonsillectomy  Gall Bladder  Back Surgery

Hernia  Broken Bones  Other \_\_\_\_\_

Major Accidents, falls or hospitalizations: \_\_\_\_\_

Major Family Medical History \_\_\_\_\_

Previous Chiropractic care: Yes  No

Doctor's Name and approximate date of last visit: \_\_\_\_\_

## Acknowledgements

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

\_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any named disease or entity.

\_\_\_\_\_ I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

\_\_\_\_\_ I grant permission to be called/texted to confirm or reschedule an appointment and to be sent occasional cards, letters, or emails or health information to me as an extension of my care in this office.

\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

*The purpose of our chiropractic clinic is to serve you in achieving your optimum health and reaching your goals. In the process of doing so, we try to educate you so that you may understand health and chiropractic, and, in turn, educate others.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature

Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_