



Chiropractic Registration

Patient Information:

Name: _____

Sex: Male Female DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Marital Status: Married Single Other

Referred By: _____

Contact Information:

Cell Number: _____

Home Number: _____

Text Message Reminders: Yes No

Emergency Contact:

Name: _____ Relation: _____

Contact Number: _____

Can your account or health information be discussed with this person: Yes No

Insurance Information:

Billing Insurance: Yes No

Insurance Company: _____

Account Responsibility: Myself Other

Responsible Party (if other): _____

Insurance / Financial Assignment:

I certify that I – or a dependent have insurance coverage with the above listed insurance company and assign directly to Connected Chiropractic all benefits. The above doctor/clinic and its legal representatives may use and disclose my health information to the above-named insurance company (or future insurance companies) for use of obtaining payment or benefit information.

I am responsible for all charges regardless of insurance coverage or non-payment by my insurance company. I authorize the use of my electronic signature on all insurance submission forms. If prior authorization is required by my insurance - it is my responsibility to obtain the authorization before treatment is rendered.

Cancellation Policy:

Appointments canceled with less than 24 hour notice may be subject to a \$50 fee. This fee is not billable to insurance and is non transferable.

Patient Initials: _____

Patient Signature: _____ Date: _____

Accident Information:

Is your current condition due to an accident: Yes No

(If answer is no – leave remainder of Accident Information Blank)

Type of Accident: Auto Work Date of Accident: _____

Accident Reported To: Auto Insurance Employer Workers Compensation

Condition:

List and describe your top three areas of complaint

1) _____

Intensity: Mild Moderate Severe

Symptoms: Dull / Achy Sharp / Stabbing Burning Stiff / Tight Numb

2) _____

Intensity: Mild Moderate Severe

Symptoms: Dull / Achy Sharp / Stabbing Burning Stiff / Tight Numb

3) _____

Intensity: Mild Moderate Severe

Symptoms: Dull / Achy Sharp / Stabbing Burning Stiff / Tight Numb

Frequency of Symptoms: Constant (100%) Frequent (75%) Occasional (50%) Intermittent (25%)

Do these symptoms affect your: Sleep Work Daily Routine Recreational Activities -- ALL

What aggravates your symptoms: Sitting Standing Bending Twisting Lifting Walking Exercise
 Sleeping Sneezing/Coughing Driving Other: _____

What makes your symptoms better: Rest Ice Heat Stretching Medication Topical Creams

Who have you seen for this condition: MD/ PCP Acupuncture PT Massage None

Prior Chiropractic Care: Yes No --- If yes, when: _____

Have you had spinal x-rays within the last 5 years: Yes No

Goals for care: Short Term Symptom Relief Correction and Stabilization Other: _____

Health History:

Have you ever had any of the following:

- | | | | | | |
|----------------------|--|----------------------|--|-----------------------|--|
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | High BP | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disc Issues | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Auto Immune | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you currently taking any prescription medication: Yes No

Name of Medication: _____ Used to Treat: _____

Name of Medication: _____ Used to Treat: _____

Name of Medication: _____ Used to Treat: _____

Medication list provided to staff

Surgeries:

Have you ever had spinal surgery: Yes No

Have you ever had joint replacement surgery: Yes No

Family History:

Auto Immune Disorders: Parents Siblings Grandparents None

Cancer: Parents Siblings Grandparents None

Heart Disease: Parents Siblings Grandparents None

Neurological Disorders Parents Siblings Grandparents None

Stroke: Parents Siblings Grandparents None



CONNECTED CHIROPRACTIC
Dr. Michael Marchese

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapy, modalities, and if necessary diagnostic x-rays (performed outside clinic).

I further understand that such chiropractic services may be performed by the Doctor of Chiropractic at this office on me now, or in the future. I have had the opportunity to discuss the nature and purpose of chiropractic adjustments, and other procedures, with the provider, and I understand that results are not guaranteed.

I understand there are possible risks associated with treatment. Including, but not limited to: fracture, disc injury, stroke (CVA), dislocations, and sprains. I do not expect the provider to be able to anticipate and explain all risks or complications associated with treatment. Further, I wish to rely on the provider to exercise judgment during the course of treatment - to which the provider feels are in my best interest at the time.

I have read, or have had read to me, the above consent. I have also had opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommendations by my provider. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility, now and in the future.

Print Patient Name

Signature of Patient

Date Signed

SIGN BELOW ONLY IF PROVIDING CONSENT FOR SOMEONE OTHER THAN YOURSELF

Print Name of Legal Representative

Signature of Legal Representative

Date Signed