Activated Family Chiropractic & Wellness

13140 Coit Road, STE 514, Dallas, Texas 75240 (P)972-925-0384; (F)972-925-9163

New Patient Registration

Patient Information

Date: _____

SSN #: _____

Patient Name: _____
Last Name

_____
First Name Middle Initial

Address: _____

E-Mail: _____

City: _____

State: _____ Zip: _____

Sex: ❑ M ❑ F Age: _____

DOB: ____ / ____ /_____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

_____

Employer/School Phone: (_____) _____

Spouse's Name: _____

DOB: ____ / ____ /_____ SS#: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name: _____

DOB: ____ / ____ /_____ SS#: _____

Relationship to Patient: _____

Insurance Co: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Print Name of Signature of Patient, Parent, Guardian or Personal Representative

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Cell Phone: (_____) _____ Home Phone: (_____)

_____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____ Relationship: _____

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

Accident Information

Is condition related to an accident? ❑ Yes ❑ No Date: _____

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable): _____

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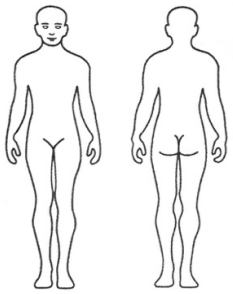
Patient Condition

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, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Health History

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None

❑ Other:_____

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: _____

Please mark on "Yes" or "No" to indicate if you have had any of the following:

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

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Health History (continued)

Exercise

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

Work Activity

- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits

- ❑ Smoking
- ❑ Alcohol
- ❑ Coffee/Caffeine Drinks
- ❑ High Stress Level

Packs/Day: _____
Drinks/Week: _____
Cups/Day: _____
Reason: _____

Are you pregnant? ❑ Yes ❑ No Due Date: _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name:		
Pharmacy Phone: (_____)		

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Consent to Treatment

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address
b. The nature of the treatment
c. The risks and benefits of that treatment
d. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with **Dr. _____ at Activated Family Chiropractic & Wellness, PLLC.**

_____

Patient signature Date

Patient Name (Print):_____

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Symptom Status Form

Patient's Name: _____Date:_____

1. Circle any of the following areas where you are experiencing pain and/or symptoms:

Neck (L) (R)	Hip (L) (R)	Face
Upper/Mid Back	Leg (L) (R)	Head
Mid/Lower Back	Knee (L) (R)	Jaw/Mouth
Shoulder (L) (R)	Ankle (L) (R)	
Arm (L) (R)	Foot (L) (R)	
Elbow (L) (R)	Chest/Ribcage	
Wrist (L) (R)	Ears (L) (R)	
Hand (L) (R)	Eyes (L) (R)	

2. Are you currently experiencing any of the following? (Circle all that apply):

Headaches	Bowel/Bladder disturbance
Dizziness	Difficulty Swallowing/Eating
Numbness/Tingling	Difficulty Walking
Fainting	Blurred Vision
Ringing in Ears	Nausea/Vomiting

3. In the past, have you ever had an injury and/or surgery to any area where you are currently having symptoms and/or pain?

NO YES

If Yes, please explain:

_____

_____

_____ _____

Patient's Initials Physician's Initials

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Release of Medical Records/Information Request

Patient Name: _____

DOB : _____

Date : _____

To Whom It May Concern:

I hereby authorize the release of the following information of my health/medical records from:

1. Hospital/Dr.'s Office _____

Telephone:_____ Fax: _____

2. Hospital/Dr.'s Office _____

Telephone:_____ Fax: _____

( ) All Medical Records, including ER reports
( ) All Diagnostic Film Reports, including X-ray, MRI, CT, etc

Records requested from _____ to present.

Please send the above stated information to:

Activated Family Chiropractic & Wellness, PLLC
13140 Coit Road, STE 514
Dallas, Texas 75240
972-925-0384- Main
972-925-9163- Fax

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Physician Signature Date

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ASSGINMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident, and Health Insurance

_____
Date

I hereby authorize and direct the _____Insurance Carrier to pay by check made out mailed directly to:

Activated Family Chiropractic & Wellness, PLLC
13140 Coit Road, STE 514
Dallas, Texas 75240
972-925-0384

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made to me and mailed as follows:

Activated Family Chiropractic & Wellness, PLLC
13140 Coit Road, STE 514
Dallas, Texas 75240
972-925-0384

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

Patient's Name: (Print)_____

_____
Signature of Policyholder Date

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Doctor's Office Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
At this clinic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom may be involved in your care.

What We (Medical Provider)May Do:	What You (Patient)May Do:
▪ We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. ▪ We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. ▪ We will share your medical information with our business associates, such as billing service. We have a written contract with each business associate that requires them to protect your privacy. ▪ We may use your information to contact you. For example, we may send you a newsletter or other information ▪ We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. ▪ We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.	• You may request in writing that we do not disclose your health information as described above. We will let you know if we can fulfill your request. • You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. • As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. • You have the right to transfer copies of your health information to another practice. We will mail your files for you. • You have the right to transfer copies of your health information to another practice. We will mail your files for you. • You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. • You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information. • You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. • You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, DC 20201. You will not be retaliated against for filling a complaint.

However before filing a complaint, or for more information or assistance regarding your health information, privacy, please contact our Privacy Officer, Dr. Joseph Surace, D.C., at 972-925-0384. This notice goes into effect as of December 7, 2015.

Acknowledgement

I have received a copy of the Doctor's Office Notice of Privacy Practices:

Signed: _____Date:_____

Print (patient) Name: _____
If signed as a parent or guardian please note the name of the Minor patient:

_____

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