PATIENT REGISTRATION FORM

Today's date:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Sex: ☐ M ☐ F

Last name: First: Middle:

Date of Birth: Age:

Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐

Street address:

City: State: Zip:

Soc.Sec # Home Ph#: ( ) Cell Ph#: ( )

Email Address:

Employer:

Occupation: Employer Ph #: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for the bill: Date of Birth:

Address (if different): Ph# (if different): ( )

Is this person a patient here? ☐ Yes ☐ No Occupation?

Employer: Employer Ph#: ( )

Employer Address:

Is this person covered by insurance? ☐ Yes ☐ No

Primary Insurance Company:

Subscriber's Name: Subscriber SS#: Subscriber Ph#: ( )

Group No.: Policy No.: Co-Payment : $

Secondary Insurance (if applicable):

Subscriber's Name: Subscriber SS#: Subscriber Ph#: ( )

Group No.: Policy No.: Co-Payment : $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT INFO.

Name of local friend or relative:

Relationship to Patient:

Home Ph#: ( ) Work Ph#: ( ) Cell Ph#: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release any information required to process my claims.

Patient/ Guardian Signature Date:

PATIENT HISTORY

1. What is your **main complaint?** _____

2. Using the scale below, indicate the **severity** of your **main complaint** (when at its worst) _____

None		***Slight***		***Mild***		***Moderate***			***Severe***
1	2	3	4	5	6	7	8	9	10

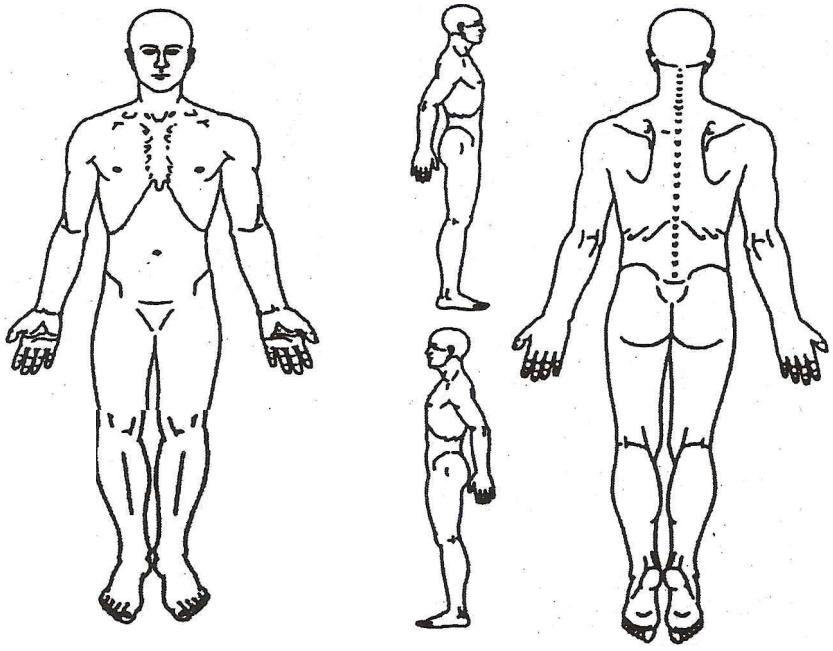
3. Using the scale below, indicate the **percentage of time** you experience your **main complaint**: _____ %

		Occasional		***Intermittent***		• ***Frequent***		• ***Constant***	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

4. How long have you been experiencing your **main complaint**? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING PAIN **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



6. When do you notice it most? ☐ AM ☐ PM
How long does it last? _____ Mins. _____ Hrs.

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? ☐ Yes ☐ No

10. I have: ☐ been hospitalized ☐ been treated by another chiropractor ☐ been treated by another specialty provider ☐ never received care for this problem

11. Have you lost time from work because of it? ☐Yes ☐No
Dates? from _____ to _____

12. Are you pregnant? ☐Yes ☐No

13. What was the first day of your last menstrual cycle? _____
Number of pregnancies? Miscarriages?

Do you have **pain** and/or difficulty performing any of the following activities: (Check):

personal care	☐Yes	☐No
lifting	☐Yes	☐No
reading	☐Yes	☐No
concentrating	☐Yes	☐No
work	☐Yes	☐No
driving	☐Yes	☐No
sleeping	☐Yes	☐No
recreation	☐Yes	☐No
walking	☐Yes	☐No
sitting	☐Yes	☐No
standing	☐Yes	☐No
social life	☐Yes	☐No

Signature: _____
Date: _____

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) all conditions you are currently experiencing, or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Please complete all lines without leaving any blanks.

High Blood Pressure	☐C ☐P ☐NA		
Dizziness/Fainting	☐C ☐P ☐NA		
Insomnia	☐C ☐P ☐NA		
Low Resistance	☐C ☐P ☐NA		
Tension	☐C ☐P ☐NA		
Confusion	☐C ☐P ☐NA		
Fatigue	☐C ☐P ☐NA		
Ulcers	☐C ☐P ☐NA		
Eye/Vision Problems	☐C ☐P ☐NA		
Ear/Hearing Problems	☐C ☐P ☐NA		
Difficulty Breathing	☐C ☐P ☐NA		
Heart Problems	☐C ☐P ☐NA		
Loss of Bladder Control	☐C ☐P ☐NA		
Constipation	☐C ☐P ☐NA		
Diarrhea	☐C ☐P ☐NA		
Digestion Problems	☐C ☐P ☐NA		
Nausea	☐C ☐P ☐NA		
Female Problems	☐C ☐P ☐NA		
Prostate Problems	☐C ☐P ☐NA		
Diabetes	☐C ☐P ☐NA		
Cold Hands/Feet	☐C ☐P ☐NA		
Hand Tremors	☐C ☐P ☐NA		
Loss of Memory	☐C ☐P ☐NA		
Nervousness	☐C ☐P ☐NA		
Sweaty Palms	☐C ☐P ☐NA		
Speech Difficulty	☐C ☐P ☐NA		
Anxiety	☐C ☐P ☐NA		
Depression	☐C ☐P ☐NA		
Irritability	☐C ☐P ☐NA		

FOR DOCTOR USE ONLY

Dr. Reviewed	Systems	Symptoms
	General	Weight changes, fatigue, anorexia, weakness, fever, chill, changes in activity
	Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
	Head	Trauma, headaches, dizziness, light headed.
	Eyes	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, cortomata, pain, excessive lacrimation, redness, discharge
	Nose	Rhinorrhea, epistaxis, allergies, alrway obstruction
	Mouth & Throat	Ulcers, tooth pain/extractions, tempormanbibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
	Neck	Stiffness, lumps/swelling/masses, pain
	Lungs	Cough (productive/nonproductive), hemopysis, dyspnea, pain with respiration, wheezing, night sweats.
	Cardiac	Palpitations, chest pain, orhopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
	Breasts	Self-examination, frequency/results, pain, nipple discharge, lumps/masses, skin dimpling.
	Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
	Genitournary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematurea, sexually transmitted disease, dyspareunia, scrotal mass (male), hernia
	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitsm, menstruation history, pregnancy history, dysmonorrhea, premenstrual syndrome, climacteric
	Hematopoletic	Anemia, abdominal bleeding, lymph node elargement/pain.
	Musculoskelatal	Bone/Joint pain, selling, joint deformity, trauma, restricted range of motion, weakness, atrophy
	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paraly-sis, tremors, staxis, loss of balance, numbness, parenthesia
	Psychological	Mood swings, depression, anxiety, phobias

Do you or have you had any medical problems with your heart, kidneys, gallbladder, thyroid, liver, allergies, ulcers or other?_____

Are you currently taking any medication, vitamin or supplement?_____

How often do you drink alcoholic beverages?_____
Do you smoke? ☐YES ☐NO How much?_____
Do you exercise? ☐YES ☐NO How much?_____

FOR DOCTORS USE ONLY

☐ Reviewed External H P
☐ Release Records H P
☐ Request Records H P

Please identify all facilities/providers you have seen for above conditions and those you are currently seeing, if any, for your presenting problem(s)

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT REC'D	FROM WHEN TO WHEN

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____	**Last Name**:_____

Email address: _____@_____
Height: _____ Weight:_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker/Never Smoked **Smoking Start Date (Optional): _____**
CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?(Include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to receive my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____Date: _____

For office use only	Blood Pressure:_____ /_____	Pulse:_____

Healing Touch Chiropractic and Rehab
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Healing Touch Chiropractic and Rehab is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or health care operations. (example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care professionals associated with Healing Touch Chiropractic and Rehab."
>
> "It is our policy to provide a substitute health care provider, authorized by Healing Touch Chiropractic and Rehab, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Worker's Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation & Research
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing and Other Communications
We may contact you for marketing purposes or fundraising purposes, as described below:

> "As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."
>
> "It is our practice to occasionally participate in charitable events. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will inform you of the type of activity, the dates and times, and request your participation in such event. It is not our policy to disclose health information about you for the purpose of Healing Touch Chiropractic and Rehab's sponsored fund-raising events."

Change of Ownership
In the event that Healing Touch Chiropractic and Rehab is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restriction on certain uses and disclosures of your health information. Please be advised; however, that Healing Touch Chiropractic and Rehab is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Healing Touch Chiropractic and Rehab amend your protected health information. Please be advised; however, that Healing Touch Chiropractic and Rehab is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Healing Touch Chiropractic and Rehab.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon your request.

Changes to this Notice of Privacy Practices

Healing Touch Chiropractic and Rehab reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Healing Touch Chiropractic and Rehab is required by law to comply with this Notice.

Healing Touch Chiropractic and Rehab is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Grace Ryoo by calling the main office at 623-521-8190. If Grace Ryoo is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints

Complaints about your privacy rights or how Healing Touch Chiropractic and Rehab has handled your health information should be direct to Grace Ryoo by calling the main office at 623-521-8190. If Grace Ryoo is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Healing Touch Chiropractic and Rehab with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date