McDowell Chiropractic Patient Registration

Name _____ Date _____

Address _____ City _____ ST ____ Zip_____

Birthdate _____ Sex_____ Social Security Number _____

Phone _____ Cell_____ Cell Phone Carrier_____ Text Reminders___

Email_____ Email Reminders_____

Marital Status _____Spouses Name _____ Number of Children_____

Occupation _____ Employer _____ City _____ ST____

Emergency Contact_____Relation_____ Phone_____

Referred By_____

Primary Care Physician_____ Phone_____ May we Contact ___

Personal History Of: Anemia, Appendicitis, Arthritis, Asthma, Anxiety, Back Pain, Bipolar, Broken Bones, Cancer, Cervical Fusion, Chest pain, Chronic Fatigue, Depression, Diabetes, Dizziness, Epilepsy, Eye/vision problems, Fainting, Fatigue, Fibromyalgia, Foot Pain, Genetic Spinal Disorder, Gout, Hand Pain, Headaches, Hearing problems, Heart Disease, Hepatitis, Hernia, Herniated Disc, High Blood Pressure, High Cholesterol, Hip Pain, Implants, Jaw pain, Joint Stiffness, Kidney Disorder, Kidney Failure, Knee pain, Leg pain, Liver Disease, Low back Pain, Lumbar Fusion, Mid Back pain, Migraines, M.S., Neck Pain, Neuropathy, Osteoarthritis, Osteoporosis, Pacemaker, Parkinson's Disease, Plantar Faciatis, Prostate problems, Prosthesis Implants, Rheumatoid, Scoliosis, Seizures, Shoulder pain, Spinal cord injury, Stomach problems, Stroke, Thyroid, TMJ, Ulcers, Vertigo, Whooping Cough, Wrist pain,
Other_____

Previous Surgeries & Dates_____

Do you Smoke____ Amount Per Day_____ Drink Alcohol_____ Amount Per Day_____

What if any Exercises do you do? _____

List ALL Medications Supplements & OTC

_____

_____

Were you hurt: At Work_____ Auto Accident_____ Other_____

Workers Comp: Have you filed an injury report with your employer? If so date_____

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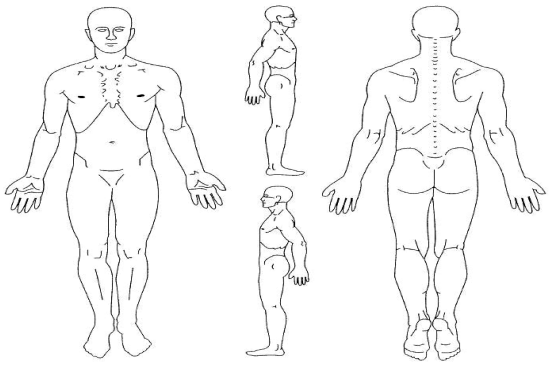
Major Pain or Problem Today_____ Date Started_____

How did it happen?

_____

_____

Are you Pregnant? _____ Date of Last X-Rays _____ By Whom_____



Please Mark Areas of Pain on left

I would rate the intensity of my Symptoms as:

0 1 2 3 4 5 6 7 8 9 10

Symptoms described as: Mild Moderate Severe Unbearable None

Condition is Getting: Better Same Worse No Change

Pain is described as: Burning Dull Ache Numb Sharp Tingle Other _____

Symptoms describes as: Constant Occasional Intermittent Frequent

What activities aggravate your condition? Sitting Standing Lying Lifting Riding Hot Cold

What activities lessen your pain? Sitting Standing Lying Riding Hot Cold

Is this condition interfering with: Work Sleep Routine Driving Cleaning Other_____

Other Doctors that you have seen for this condition _____

Any Home Remedies? _____

Have you had any previous accidents or injuries? _____

All questions on this form have been answered accurately. I understand that giving incorrect information can be dangerous and affect the doctor's ability to diagnose and provide treatment for my condition.

If you are accepted as a patient of McDowell Chiropractic, you are expected to pay at the end of each visit unless other arrangements are approved.

Our office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for all payments including but not limited to co-pays, deductibles, co-insurance amounts and any fees not paid by your insurance company.

Patient Signature _____ **Date** _____

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law health care providers need to give **patients who don't have insurance or who are not using insurance, if requested,** an estimate of the bill for medical services. If you receive a bill that is at least $400.00 more than your good Faith Estimate, you can dispute the bill.

Patient Initial_____

Assignment and Release

I, the undersigned, assign directly to Dr. Lynn Burgin, all benefits, if an otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I authorize McDowell Chiropractic, Inc. to endorse any insurance checks made out in my name to be put towards my account on any outstanding balance. I understand that all original documents created will remain the property of McDowell Chiropractic, Inc. McDowell Chiropractic, Inc. and Dr. Lynn Burgin, D.C. will not be held responsible for any undisclosed pre-existing condition.

Patient Signature_____ **Date**_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
spinal manipulative therapy palpation vital signs range of motion testing orthopedic testing basic neurological testing muscle strength testing postural analysis ultrasound hot/cold therapy electrical stimulation radiographic studies mechanical traction
Other (please explain) _____

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have not read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert doctor's name)* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.
Dated: _____

_____/_____/_____
Print Patient's Name Patient's Signature Signature of Parent of Guardian (if minor)

Lynn Burgin D.C.___/_____Dated: _____
Dr.'s Name Dr.'s Signature

HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

I authorize the use and disclosure of my medical information to the following:

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Print Name_____

Patient Signature_____ **Date**_____