BREAKTHROUGH **Chiropractic Clinic, Inc.**

REGISTRATION FORM

(Please Print)

Today's date:	Family Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Email Address:	Height " / Weight: lbs.	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ BCBS	❑ Cigna	❑ United Healthcare	❑ Accordia	❑ Medcost

❑ Rutherford Health Plan	❑ Medicare	❑ Medicaid	❑ Carolina Access Medicaid	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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

The patient understands and agrees to allow this

Patient/Guardian signature *Date*

HISTORY - PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

What is your major symptom? ____

What does this prevent you from doing or enjoying? ______________________________

If this is a recurrence, when was the first time you noticed this problem? ______________________

How did it originally occur? ____

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually Worse

If yes, when and how? ____

How frequent is the condition? □ Constant □ Daily □ Intermittent □ Night Only

How long does it last? □ All Day □ Few Hours □ Minutes

Are there any other conditions or symptoms that may be related to your major symptom? □ Yes □ No

If yes, describe: ____

Are there other unrelated health problems? □ Yes □ No

If yes, describe ______________________________

Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □ Aching □ Burning □ Stabbing

Other ____

Is there anything you can do to relieve the problem? □ Yes □ No.

If yes, describe ____

If no, what have you tried to do that has not helped? ______________________________

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting

Other ____

List any major accidents you have had other than those that might be mentioned above: ______________________

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WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ Yes □ No □ Uncertain

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:____Date:________________

Guardian's Signature Authorizing Care:__________________________________Date:________________

Doctor's Remarks: ____

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Doctor's Signature ____ Date: ______________