Advanced Chiropractic Rehab Center, PC
519 Bloomfield Avenue, #L21
Caldwell, NJ 07006
(973) 228-8600
AdvancedChiroRehabCaldwell.com

REGISTRATION FORM

Today's Date ____/_____/_____ Chart #: _____

PATIENT INFORMATION

Patient's Last Name First M.I.			☐ Mr. ☐ Miss ☐Mrs. ☐Ms. ☐ Dr.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Social Security #. - -	Home Phone #( )	Cell Phone # ( )	Birth Date / /	Age	Sex ☐ M ☐ F
Street Address	City	State	Zip Code	Email Address	
Occupation	Employer			Employer Phone #. ( )	
Employer Address	City	State	Zip Code		

Who may we thank for referring you? ☐ Patient _____ ☐ Dr._____

☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Other _____

Primary Care Physician (PCP)	PCP Street Address	PCP Phone #. ( )

WORK OR ACCIDENT INFORMATION (PLEASE FILLL OUT ALL INDFORAMATION REQUESTED IF APPLICABLE)

Is Injury Work or Auto related?	Date of Injury _____/_____/_____	Name/Address of Insurance Carrier (For Claims)	Adjusters Name and Phone #. ( )
Claim #.	Injury Report Filed? ☐ Yes ☐ No		
Attorney Name		Attorney Address	Attorney Phone #. ( )

COMMERCIAL INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Is patient covered by insurance? ☐ Yes ☐No Primary Insurance Type ☐ HMO ☐ PPO ☐Indemnity ☐Other_____

Please indicate primary insurance: ☐ Medicare ☐ Medical Mutual ☐ BCBS ☐ United HealthCare ☐ CIGNA ☐ Aetna ☐ Ameri Health ☐ Anthem Traditional ☐ Other _____

Subscriber's Name	Subscriber's S.S.# - -	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group # Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship	Home Phone #. ( )	Work/Cell #. ( )

The above information is true to the best of my knowledge. I assign directly to Advanced Chiropractic Rehab Center all Medical 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 my insurance. I hereby authorize my doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: X _____ Date:_____/_____/_____

Date: ____/____/____ **HEALTH HISTORY** File #: _____

Name: ☐ **M**
(*Last, First, M.I.)* ☐ **F** **DOB** ____/____/____

What is the reason for your visit?

What do you think caused this problem?

PERSONAL HEALTH

Please list any current medical conditions or symptoms you are experiencing, or have experienced during the past

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name	Condition	Dosage	Frequency Used

Please Provide details of any known allergies. (e.g., latex, medications, food)

Allergen	Reaction

HEALTH

Exercise:	☐Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 minutes) ☐Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Diet:	Are you dieting? ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? ☐Yes ☐ No # of meals you eat in an average day? _____
Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____
Alcohol:	How many alcohol containing beverages do you consume: daily _____ weekly _____
Tobacco:	Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes _____Pk/day # of years _____☐or Year Quit _____
Sleep:	Does your complaint disrupt your sleep? ☐Yes ☐ No
Stress:	Please rate your daily stress level: (*None)* 1 2 3 4 5 6 7 8 9 10 (*Terrible)*
Pregnancy / Children:	# pregnancies ____# Birth children ____

FAMILY HEALTH

PLEASE HELP US TO IDENTIFY YOUR POTENTIAL HEALTH RISKS BY PLACING A CHECK IN ANY COLUMN THAT APPLIES TO YOU OR

Condition / Body System	Self	Grandparent	Parent	Sibling	Child
Aids / HIV					
Arthritis					
Bleeding disorders					
Cancer					
Endocrine / glandular (diabetes thyroid)					
Hepatitis					
Immune					
Stroke / TIA					
Circulatory Problems (blood, vessels, heart)					
Ear , Nose, Throat					
Heart Problems					
High Blood Pressure					
Neurological (brain, nerves)					
Gastrointestinal (stomach, Intestines)					
Muscle / Joint / Bone					
Genitourinary (urine, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

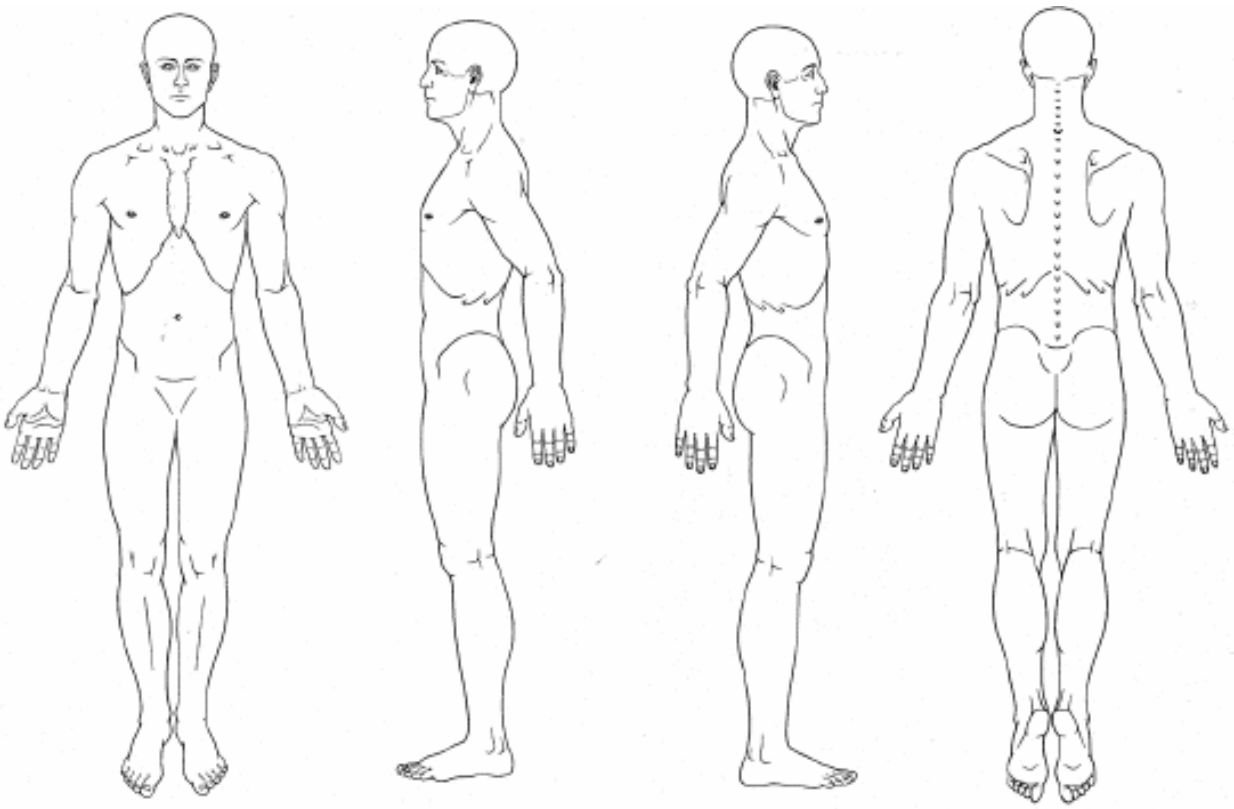
Patient Signature _____ Date _____/_____/_____

Name: _____ Date: _____/_____/_____ File:_____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness - - - - **Pins & Needles** oooo **Burning** xxxx **Aching** **** **Stabbing** ////



Please place a vertical mark on the line below to indicate the severity of your complaint.

Neck Pain No Pain |——————————————————| Worse Pain Imaginable

Low Back Pain No Pain |——————————————————| Worse Pain Imaginable

Other_____ No Pain |——————————————————| Worse Pain Imaginable

Patient Signature _____ Date _____/_____/_____

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Informed Consent for Examination and Treatment

I hereby request and consent to the performance of Chiropractic adjustments, and other Chiropractic procedures, including various modes of physical therapy, on me (or the patient named below, for whom I am legally responsible) by the doctor of Chiropractic named below and or other licensed doctors of Chiropractic who now or in the future treat me while employed by, working or associated with the serving as back-up for the doctor of Chiropractic name below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinical personnel the nature and purpose of Chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment. Including but not limited to, fracture, disc injuries, stroke, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named person procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Print Patient's Name: _____

Signature:_____ Date: ____/____/_____

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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.

Your Rights:

RIGHT OF ACCESS: You may inspect and request a copy of certain health information we have about you. We have forms for such requests. These requests must be made in writing and must be directed to our officer listed on the first page of this notice. We will provide a copy in format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If you are the recipient of electronic notice, you may obtain a paper copy upon request.

We will charge a reasonable, cost-based fee when asked to provide copies of your health information. Charges will include costs for copying at .50 cents per page, postage, and staff time at the rate of $15.00 per hour. If you request a summary of your health information, we will provide it, charging staff time at the hourly rate shown above. If you have any questions about our fees for these services, please contact us using the contact information provided.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. Such requests must be made in writing and must include a reason to support the request. Under some circumstances, we may deny such a request, but you are entitled to a written response within 60 days of our receipt of your written request.

Rights to Request Restrictions: You may request that we restrict uses or disclosures or certain health information about you to carry our treatment, payment, or health care operations. We may not (and are not required to) agree to requested restrictions. We will not use or disclose any health information about you in violation or any restrictions that we agree to other than in providing emergency treatment.

Confidential Communications: Alternative Means, Alternative Locations: You may ask to receive communications of health information by alternative means or at an alternative location. We will accommodate all reasonable requests. You must provide this type of request to us in writing and provide an alternative method of contact of alternative address. We will provide an estimate of the fee for service in advance and ask that you provide information as to how payment will be handled.

Accounting of Disclosures: You have a right to receive an accounting of disclosures we have made of health information about you for the 6 years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations, and certain other disclosures. The first such accounting we provide within any 12 month period will be without charge to you. We will charge a reasonable, cost based fee for each subsequent request for an accounting within a 12-month period. We will notify you in advance of this fee.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive the notice electronically, you may still obtain a paper copy. To obtain a paper copy, ask any Advanced Chiropractic Rehab Center staff member.

Changes to This Notice: We reserve the right to change the terms of this notice and to make the changed notice provisions effective for all health information we have about you or could receive in the future. We will promptly revise, post, and distribute a revised notice whenever there is a material change to the uses or disclosures, individual rights, our legal duties, or other privacy practices discussed in the notice. Our privacy notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting:

Advanced Chiropractic Rehab Center, PC
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You may also file a written complaint with the U.S. Department of Health and Human Services by contacting:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, D.C. 20201
Toll Free: 1-877-696-6775

This privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgment of Receipt of Privacy Practices:

I, _____ have received a copy of Advanced Chiropractic Rehab Center, PC notice of privacy practices.

_____(Patient/Guardian Signature)_ Date:_ ____/___ __/_____