CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: M F Age: _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to the Patient _____

Insurance Co. _____

Group # _____

Is the patient covered by additional insurance? YES NO

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext ____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is this condition due 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) _____

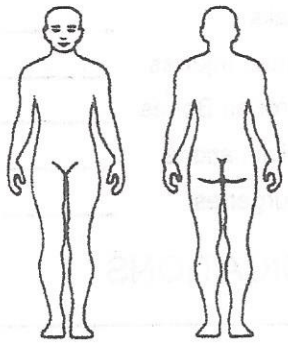
5 PATIENT CONDITION

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 TINGLING 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

6 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 Circle "YES" or "NO" to indicate if you have had any of the following:

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

EXERCISE

None_____
Moderate_____
Daily_____
Heavy_____

WORK ACTIVITY

Sitting_____
Standing_____
Light Labor_____
Heavy Labor_____

HABITS

Smoking Packs/Day_____
Alcohol Drinks/Week_____
Coffee/Caffeine Drinks Cups/Day_____
High Stress Level Reason_____

Are you pregnant? YES NO Due Date_____

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

7 MEDICATIONS

_____
_____
Pharmacy Name_____

ALLERGIES

_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____

HIPAA NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

Family Chiropractic is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers.

AUTHORIZATION

Uses and/or disclosures, will be made only with your *written* Authorization. These authorizations may be revoked at any time, however, we cannot take back disclosures already made with your permission. We also will NOT use or disclose your PHI for the following purposes, where applicable, without your express *written* Authorization:

1. Marketing - This does not including marketing communications described in item #19. The Practice will obtain prior authorization before disclosing PHI in connection with marketing activities in which financial remuneration is received.

2. Sales - The Practice may receive payment for sharing your information in specific situations (i.e. publichealth purposes or specific research projects - see #12 above).

3. Specially protected information - Certain types of information such as psychotherapy notes, HIV status, substance abuse, mental health, and genetic testing information require their separate written authorization for the purposes of treatment, payment or healthcare operations.

YOUR RIGHTS

You have the right to:

• Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Marketing revocations may be submitted to the Practice via telephone or email.

• Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

• Restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Practice.

• Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

• Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee (to cover costs incurred by the Practice to reproduce records) for the cost of copying, mailing or other supplies associated with your request.

• Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the originating individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

• Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

X _____ Date _____

Alicia Bolzenius
611 Hwy. 50 West
Union, MO 63084
(636)584-7900
Fax: (636) 583-8897

Consent to Treat a Minor Child

I hereby authorize Dr. Alicia Bolzenius and whomever she may designate as her assistance to administer treatment, as she so deems necessary to_____ _____this_____ day of _____.

Signature of Parent or Guardian: _____

Witnessed:___ _____

Date: _____

**** If a parent won't be accompanying a minor to their appointment and they're under the age of 18, a guardian must sign this form prior to the appointment