PATIENT REGISTRATION

Date: _____

Last Name_____First Name_____M.I_____Nickname_____

Address_____City_____State_____ Zip_____

Mobile Phone_____Home Phone_____Work Phone_____

E-Mail_____SSN _____

Date of Birth_____ Age_____ Gender: M F Marital Status: S M W D

Employer Name_____Occupation_____

Spouse Name_____Phone_____Employer/Occupation_____

Children (names, ages) _____

INJURY INFORMATION

Date of injury: _____

Please write a brief description of how your injury occurred:

_____

_____

_____

If your injury is NOT due to an automobile collision, please skip to the section titled "Areas of Complaint"

UPON IMPACT (**Please CIRCLE the option that applies**) :

Were you stopped? Yes / No If no, approximate speed:_____mph

Was the other vehicle stopped? Yes / No If no, approximate speed:_____mph

Was your body straight in your seat? Yes / No if no, turned to the Left / Right

Were you looking straight ahead? Yes / No if no, was your head turned to the Left / Right

Were you aware that you were about to be hit? Yes / No

Were you wearing a seatbelt at the time of the accident? Yes / No

Did your chest / head hit the steering wheel? Yes / No Did an airbag deploy? Yes / No

Did your head hit the Windshield / Side Window? Yes / No Did your shoulder hit the door? Yes / No

Did your knees hit the dashboard? Yes / No Did the seat break? Yes / No

Do you have any cuts / bruises from the accident? Yes / No If yes, where? _____

Was your car equipped with headrests? Yes / No

If yes, at what height was the top of the headrest? Base of head / Mid head / Top of head

Did you lose consciousness? Yes / No If yes, how long _____

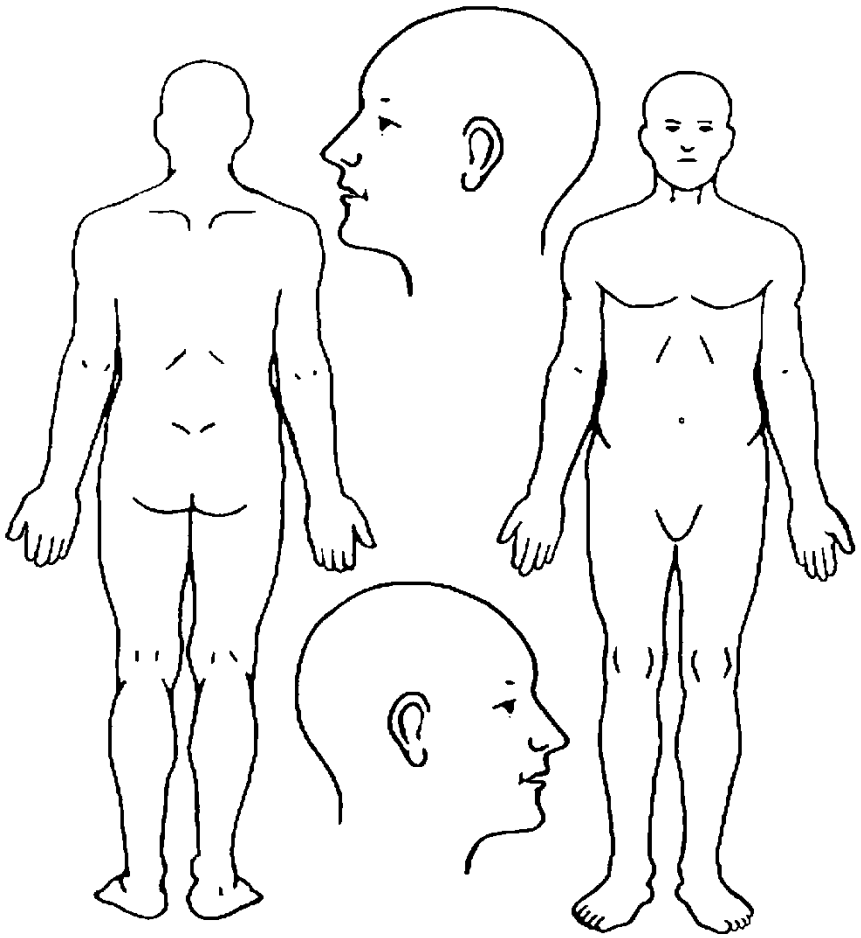
NAME: _____ Date: _____

BORG PAIN SCALE

On a scale of 1-10, please rate your pain level.

Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Please place "X's" where you feel your pain.



3190 S. State Rd 7 Suite 12B Miramar, FL 33023 TEL 954-961-0511 FAX 954-961-0519
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Are you experiencing any of the following since your injury? (Check all that apply)

____ Dizziness/Loss of balance	____ Headaches	____ Upper Back Pain
____ Neck Pain	____ Mid Back Pain	____ Low Back Pain
____ Wrist/Hand Pain	____ Elbow Pain	____ Hip Pain
____ Knee Pain	____ Ankle Pain	____ Foot Pain
____ Numbness/Tingling to leg	____ Numbness/Tingling to arm	____ Shoulder Pain
____ Chest Pain	____ Anxiety	____ Fatigue
____ Sore Throat	____ Breathing Problems	____ Digestive/Urinary

TREATMENT INFORMATION

List all the doctors that you have seen as a result of your injuries:

Date	Doctor/Hospital	Treatment
1.		
2.		
3.		

Do you have any future appointments with any doctor regarding your injuries? ☐ Yes ☐ No

HEALTH HISTORY

Medications

1. _____
2. _____
3. _____

Please list all past surgeries, major illnesses or diseases, hospitalizations (with approximate date)

1. _____
2. _____
3. _____

Please list any previous accidents and injuries:

1. _____
2. _____
3. _____

Family History

Mother's Side:	Heart Disease	Stroke	Arthritis	Cancer	Diabetes	Other_____
Father's Side:	Heart Disease	Stroke	Arthritis	Cancer	Diabetes	Other_____

Females: Are you pregnant? Yes ☐ No ☐ If so how many weeks? _____

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Patient Name: _____ Date: _____

Activities of Daily Living

ACTIVITY / Pain Scale	I can perform this activity normally, without pain / discomfort / difficulty	I can perform, but with a little pain / discomfort /difficulty	I can perform, but with significant pain /discomfort /difficulty	I can perform, with help from others	I cannot perform this activity at all
SCALE ->	0	1	2	3	4
1. Sitting					
2. Standing					
3. Walking					
4. Bending					
5. Lifting					
6. Showering					
7. Dressing					
8. Sleeping /Lying Down					
9. Exercising					
10. Driving					
List below any other activities that are difficult, painful, or uncomfortable to perform.					
11.					
12.					

Job Description:

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TERMS OF ACCEPTANCE

When a person seeks chiropractic, medical and rehabilitation health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective: to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- Health/Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
    - In-Network Policies: We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement. Co-pays will be paid by patient, reimbursement checks will be payable to us.
    - Out-of-Network Policies: We will give you receipts to file with your insurance company. Patient will pay cash prices up front. Insurance company will reimburse the patient.
    - If your policy has a deductible feature, it is due at the time of service.
    - We will do our very best to answer any questions you may have in regard to your insurance.

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

Patient signature: _____ Date: _____

INFORMED CONSENT

I hereby request and consent to the performance of medical, chiropractic adjustments and other chiropractic procedures,including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by any other physician.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minorcomplications.

PROBABILITY OF RISKS OCCURING

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BECONSIDERED

- *Over-the-counter analgesics*. Temporarily relieves pain but does not address the cause of the symptoms. Masking the pain means you may not feel additional damage. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, injections, and analgesics. Temporarily relieve pain but donot address the cause of the symptoms. Masking the pain means you may not feel additional damage. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changesincluding arthritis. These changes make future rehabilitation moredifficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **W.H. Medical Management dba MED PLUS CENTERS**.

I understand that the Notice describes the uses and disclosures of my protected health information by **W.H. Medical Management dba MED PLUS CENTERS** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient butit could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

Employee Name

Today's Date

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