CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is 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) _____

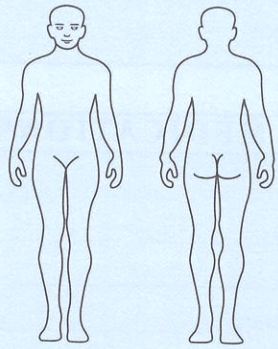
5 PATIENT CONDITION

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 _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

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

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I Wish To Be Contacted In The Following Manner (check all that apply)

☐ Home Telephone_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Telephone_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number

Other: _____

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures, information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES FOR TPO MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY

Records of Disclosures of Protected Health Information

DATE	DISCLOSED TO WHOM ADDRESS OR FAX NUMBER	(1)	DESCRIPTION OF DISCLOSURE/ PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	(2)

PRIVACY PRACTICES ACKNOWLEDGELMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate: _____
Signature: _____
Date: _____

Gary R Lipkin, D.C.
300 E. Loop 281
Longview, TX 75605
Phone: 903-234-2225

Assignments of Benefits

I authorize the doctor named above to use my name on all claims or documents that relate to health insurance benefits due to me and my dependents.

I authorize the release of any information related to any claims to all my insurance companies or other relevant parties.

I understand that I am responsible for my bill and agree to pay all charges for services and medical supplies provided to me.

I authorize and direct my doctor to act as my agent in helping me obtain payment from the insurance companies.

I authorize and direct payment of health benefits otherwise payable to me, directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

This "Signature on File" is valid for two years from the date indicated below.

_____ _____ _____

Signature of Beneficiary: Guardian or Personal Representative | Medicare # | Date

_____ _____

Please Print Beneficiary or Personal Representative | Relationship to Beneficiary

LONGVIEW CHIROPRACTIC CENTER

YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY OYUR PROTECTED HEALTH INFORMATION
Under federal law, however, you may not copy or inspect the following records; psychotherapy notes; information compiled in
reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding or protected health information that
is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO RESPECT A RESTRICTION OF YOUR PROTECTED HEALTH INFORMAITON
This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment,
payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to
family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices.
Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician or dentist is
not requiring agreeing to a restriction that you may request. If a physician or dentist believes it is in your r best interest to permit use
and disclosure of your protected health information, your protected health information will not be restricted. You then have the right
to use another Healthcare Professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION.

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US.
Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

YOU HAVE THE RIGHT TO HAVE YOUR PHYSYCIAN OR DENTIST AMEND YOUR PROTECTED HEALTH INFORMATION.
I few deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal
to your statement and will provide you with a copy of such rebuttal.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE. IF SAY, OF YOUR PROTECTED HEALTH INFORMATION.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling complaint.

THIS NOTICED WAS PUBLISHED AND BECOMES EFFECTIVE ON OR BEFORE APRIL 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices
with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have recieved this Notice of our Privacy Practices.

_____
Patient Signature