

# Neighborhood Chiropractic and Acupuncture LLC Registration and History

## PATIENT INFORMATION

Last Name:	Date:
First Name	Middle Initial:
Address:	
City:	State:                      Zip:
Cell Phone Number:	Home Phone Number:
Email:	May we send you e-mail correspondence? <input type="radio"/> Yes <input type="radio"/> No
Sex: <input type="radio"/> M <input type="radio"/> F	Pronoun Preference: <input type="radio"/> He <input type="radio"/> She <input type="radio"/> They <input type="radio"/> Ze <input type="radio"/>
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partnership <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Minor	
Birthdate:	Age:
Occupation:	
Patient Employer and/or School:	
Work Phone Number:	May we call you at work? <input type="radio"/> Yes <input type="radio"/> No
Who is responsible for this account? <input type="radio"/> Self <input type="radio"/> Insurance Company <input type="radio"/> Guardian Name:	
Who do we thank for referring you?	

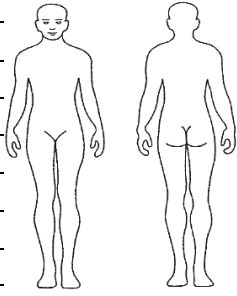
## In Case of Emergency, Contact

Name:	Relationship:
Home Phone:	Work Phone:
Primary Care Physician:	Phone Number:

## ACCIDENT INFORMATION

Is this condition due to an accident? <input type="radio"/> Yes <input type="radio"/> No	Date of Accident:
Type of Accident: <input type="radio"/> Auto <input type="radio"/> Work <input type="radio"/> Home <input type="radio"/> Other:	
To whom have you made report of your accident? <input type="radio"/> Auto Insurance:	
<input type="radio"/> Employer <input type="radio"/> Worker Comp. <input type="radio"/> Other:	
Claim # (if applicable):	Attorney Name (if applicable):

## PATIENT CONDITION

Reason for your visit	
When did your symptoms appear?	
Is this condition getting progressively worse? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know	
Mark an X on the picture where you have pain, numbness, or tingling.	
Areas of your body that need special attention? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Describe:	
Rate the severity of pain from 1 (least pain) to 10 (most pain):	
Type of pain: <input type="radio"/> Sharp <input type="radio"/> Dull <input type="radio"/> Throbbing <input type="radio"/> Numbness <input type="radio"/> Aching <input type="radio"/> Shooting <input type="radio"/> Burning	
<input type="radio"/> Tingling <input type="radio"/> Cramps <input type="radio"/> Stiffness <input type="radio"/> Swelling <input type="radio"/> Other (describe):	
Location of numbness or tingling:	
How often do you have these symptoms?	
Is it constant or does it come and go?	
Does it interfere with your: <input type="radio"/> Work <input type="radio"/> Sleep <input type="radio"/> Daily Routine <input type="radio"/> Recreation	
Activities that are painful: <input type="radio"/> Sitting <input type="radio"/> Standing <input type="radio"/> Walking <input type="radio"/> Bending <input type="radio"/> Lying Down <input type="radio"/> Lovemaking <input type="radio"/> Other	
Are you experiencing any other symptoms in your body?	





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## HIPAA Policy – Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practice of Neighborhood Chiropractic and Acupuncture which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health information created, received, or maintain by the Practice.

## Missed/Cancellation Policy

When you make an appointment, you're paying for the practitioner's time. Appointments require a 24-hour business day cancellation notice. For Saturday, Sunday, and Monday appointments, cancellation must occur prior to Friday at noon. **If we do not receive 24-hour business day notice, you will be charged a \$25 appointment cancellation fee.** We are unable to bill insurance companies for missed appointments. Thank you for your understanding of this matter.

## Communication Consent

We are adding different communication options to provide you with more personalized and integrative ways to inform you about your care. In order to communicate information regarding your care, account, appointments, and the clinic, we need permission to do so. We will never sell any of your information, nor use it for unsolicited marketing purposes.

By signing this, you authorize Neighborhood Chiropractic and/or our automated third-party reminder service to contact you and/or named authorized person(s) and to convey Personal Health Information by the following methods and assume responsibility to notify Neighborhood Chiropractic whenever this information changes.

Text Message:  Yes Text: \_\_\_\_\_  
 No, provider may not contact me by text message.

Detailed Voicemail:  Yes Phone: \_\_\_\_\_  
 No, Provider may only leave a name and phone number.

Detailed Email:  Yes Email: \_\_\_\_\_  
 No, provider may not contact me by email.

Please list names & relationships of other people authorized to receive information about your care:

\_\_\_\_\_

I hereby attest the above information is correct, and that I have read and understood the above policies.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_