

ROSEWOOD CHIROPRACTIC CLINIC

Patient Registration, History and Consent

Patient Name: _____ Date: _____

Address: _____ City/State: _____

Sex: _____ Birth date : _____ Social Sec: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Marital Status: _____

Insurance Subscriber: _____

Referred by: _____

In Case of Emergency, Contact: _____

Relationship _____ Home Phone: _____ Work Phone: _____

Reason for visit: _____ is condition due to an accident? Y or N

Type of Accident _____

Have you had or do you now have any of the following symptoms:

- | | | | |
|------------------------------|---|----|---|
| 1. Headaches | Y | or | N |
| 2. Dizziness | Y | or | N |
| 3. Chest pain | Y | or | N |
| 4. Shortness of breath | Y | or | N |
| 5. Trouble swallowing | Y | or | N |
| 6. Nagging cough | Y | or | N |
| 7. Blurred vision | Y | or | N |
| 8. Buzzing/ringing in ears | Y | or | N |
| 9. Change in bowel habits | Y | or | N |
| 10. Change in bladder habits | Y | or | N |
| 11. Menstrual problems | Y | or | N |
| 12. Numbness or tingling | Y | or | N |
| 13. High blood pressure | Y | or | N |
| 14. Diabetes | Y | or | N |
| 15. Family history of stroke | Y | or | N |
| 16. Family history of cancer | Y | or | N |
| 17. Are you a smoker? | Y | or | N |

List any medications you are on: _____

List any allergies you have: _____

Have you been involved in any accidents lately? Y or N

Have you been hospitalized recently? Y or N

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I authorize and direct that payment be made directly to Rosewood Chiropractic Clinic for any and all insurance benefits or reimbursement for services rendered by said clinic which amounts would otherwise be payable to me under any insurance or health care plan.

I authorize the release of any information concerning my health and health care services to any insurance companies, health plans, Medicare or attorney representing me.

Patient Signature

Date

CONSENT TO TREATMENT:

I am choosing to be treated, for today and all of my future visits at this office, through the use of various types of chiropractic manipulations and several types of physiological modalities. I understand that x-rays may be ordered in the process of treating/diagnosing my condition. I realize there is no guarantee of results, and have been informed that some risks of treatment do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes and disc injury. While I do expect Dr. Dykeman to use his best judgement to choose the most appropriate care for my condition, I agree that the doctor cannot foresee every possible complication or risk, which could arise in my treatment.

Patient Signature

Date

PAYMENT AGREEMENT:

I understand that there is no guarantee that my insurance companies or health plans will cover or pay for my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

I know that I am responsible for, and agree to pay for all fees incurred at this office. I understand that any insurance benefits, which I may have, are a contracted arrangement between that insurance company and myself. This office will kindly prepare notes and reports and bill receipts as needed to aid in insurance payment/reimbursal.

Patient Signature

Date