Katherine E. Bruce, DC

Bruce Chiropractic

118 E Main St. Lancaster (740) 422-8484

Patient Registration

Patient Name: **Date:**

(First) (Middle) (Last)

Sex: Male Female **Date of Birth:** **Social Security #:**

Street Address:

City: **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Email:**

Cell Carrier: (ATT, Verizon, etc.) **Work Phone:**

Best phone # to reach you during business hours: Home Cell Work

Marital Status: Single Married (years) Widowed Separated Divorced

Language: English Spanish Other:

Race: Native Hawaiian or other Pacific White or Caucasian

American Indian or Alaska Native Black or African American

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Occupation: **Employer:**

Employer's Address:

Employer's Phone #:

Spouse: **Address:** (If differ than above)

Spouse Phone #: **Spouse Employer:**

Emergency Contact: **Relationship:**

Phone Number (s):

Family Doctor: **Referring Doctor:**

How did you hear about our office?

Do you seek help for: Back Pain Neck Pain Headache Other:

HIPPA Practice's Requirements

This Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use of release of your PHI that which is provided for under federal law
c) Is required to abide by the terms of the Privacy Notice
d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
e) Will distribute any revised Privacy Notice to you prior to implementation
f) Will not retaliate against you for filing a complaint

Effective Date: 04/14/2003

Patient Acknowledgment: By subscribing my name below, I acknowledge receipt of my copy of this Notice, and my understanding and agreement to its terms

Signed: **Date:**

Bruce Chiropractic

Billing Assignment

Patient Name: **Date:**

Injury/Accident Information

Is your condition due to an accident? Yes No **Date of Accident/Injury:**

Type of Accident: Auto Work Other:

Have you made a report of your accident: Auto Insurance Employer Work Comp Other:

Attorney Name (If applicable):

BWC Claim #: **Insurance Company:**

Insurance Information:

Primary:

Who is responsible for this account? Self Spouse Dependent Parents Other:

Subscriber/Guarantor Name: (if not self) **Social Security #:**

Relationship to patient: **Date of Birth:**

Address: **Phone #:**

Employer: **Employer Address:**

Insurance Company: **ID #:** **Group #:**

Secondary:

Who is responsible for this account? Self Spouse Dependent Parents Other:

Subscriber/Guarantor Name: (if not self) **Social Security #:**

Relationship to patient: **Date of Birth:**

Address: **Phone #:**

Employer: **Employer Address:**

Employer: **Employer Address:**

Insurance Company: **ID #:** **Group #:**

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company/companies. I assign directly to The Chiropractic Group 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:**

By signing below, I acknowledge that The Chiropractic Group has informed me that payment for services and supplies may be denied under my health insurance plan, if applicable. I agree that if denied as medically not necessary, not authorized/no referral on file, exceed benefit limits or any other reason, including non-insured, I accept full responsibility to pay The Chiropractic Group for services or supplies received.

Signed: **Date:**

Bruce Chiropractic

Patient Name: **Date:**

Present Complaint:

Have you consulted anyone else for this problem?

Is your child on any medication?

Has your child had any medical treatment/scans/x-rays/surgery?

Has your child had any childhood illnesses?

Any known allergies?

Does your child have a good diet?

Which sports does your child participate in?

Regular bowel movements?

Does your child sleep well? (How many hours per night?)

Has your child had any significant falls/accidents?

Has your child had any broken bones?

Has your child had any antibiotics or prescription medication?

Does your child take any vitamins or mineral supplements?

How would you describe your child's activity level?

Family history of medical problems?

Number/Ages of siblings?

Please circle if your child has or has ever experienced any of the following:

Constipation	Diarrhea	Hyperactivity	Attention Issues	Concentration issues	Learning difficulties
Behavioral Problems	Balance/coordination issues	Recurrent cold	Frequent Ear infection	Asthma	Scoliosis
Growing pains	Bed wetting	Headaches	Back pain	Neck pain	Sinus/allergy problems

Any other information you think might be relevant?

Prenatal/Birth

Any maternal illnesses or medical treatment during pregnancy?

Did your child follow his/her milestones? (Check if achieved)

7-9 months- sitting unaided:

9-12 months- standing unsupported:

7-10 months- crawling:

12-14 months- walks unaided:

2 years- speech:

3 years- self dressing: