Knopp Chiropractic

PATIENT REGISTRATION FORM

Date_____

Patient Name _____

Address_____

_____

Cell/Home Phone _____

Email _____

Social Security Number _____

Sex ( ) M ( ) F Age_____ Date Of Birth _____

Marital Status _____ No. Children _____

Occupation_____

Work Phone_____

IN CASE OF EMERGENCY

Name_____

Relationship_____

Phone Number_____

Referred by _____

Primary Care Physician_____

Primary Care Phone _____

INSURANCE INFORMATION

( ) I understand that Knopp Chiropractic is NOT a participating provider with any commercial, Medicaid, or VA, insurance plans. Therefore, if I do not have any of those insurances I understand that payment is due in full at the time of the visit and an insurance for will be provided for me by the office so I may submit to my insurance company.

I also understand that I am responsible to know what my out of network benefits are by calling the 1-800 number on the back of my insurance card for verification. Knopp Chiropractic is not responsible for providing or knowing this information.

( ) Medicare is my primary insurance. I assign all insurance benefits, if any, to Knopp Chiropractic. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Printed Name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

PATIENTS CONDITION

Name _____ Date _____

Reason for visit _____

Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain) _____

Describe the onset of discomfort ( ) Gradual ( ) Sudden

When did the discomfort/symptoms begin? _____

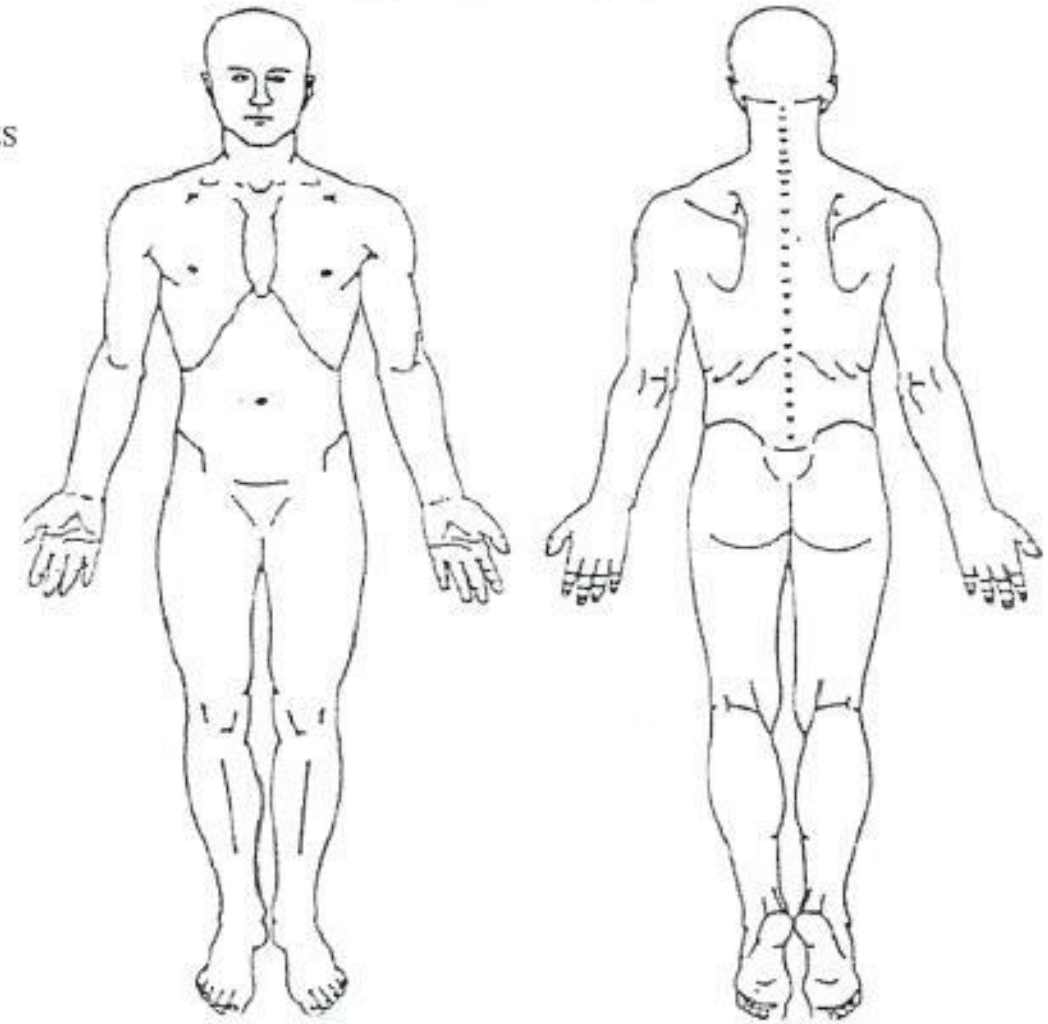
Since the problem began are the symptoms ( ) Worse ( ) Better ( ) Same

What aggravates the discomfort? ( ) Bending ( ) Carrying ( ) Lifting ( ) Lying Down
( ) Sitting ( ) Standing ( ) Twisting ( ) Walking

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting
( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling ( ) Other

On the diagram below, using the key, please indicate where you are currently experiencing pain or other symptoms.

A- ACHE
B- BURNING
N- NUMNBESS
P- PINS & NEEDLES
S- STABBING
O- OTHER



PATIENT HEALTH HISTORY

	YES	NO
Aids/HIV		
Alcoholism		
Anemia		
Anorexia		
Appendicitis		
Arthritis		
Asthma		
Bleeding Disorder		
Bronchitis		
Bulimia		
Cancer		
Chemical Dependency		
Diabetes		
Emphysema		
Epilepsy		
Goiter		
Gout		
Heart Disease		
Hepatitis		
Hernia		
Herniated Disc		
Herpes		
High Blood Pressure		
High Cholesterol		
Liver Disease		
Measles		
Migraine Headaches		
Mononucleosis		
Multiple Sclerosis		
Mumps		
Osteoporosis		
Pace Maker		
Parkinson's Disease		
Pinched Nerve		
Pneumonia		
Polio		
Prostate		
Prosthesis		
Psychiatric Care		
Rheumatic Fever		
Scarlet Fever		
Stroke		
Suicide Attempt		
Thyroid Problems		
Tuberculosis		
Ulcers		
Whooping Cough		

CURRENT MEDICATIONS

ALLERGIES

Injuries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

FAMILY HEALTH INFORMATION

Name	Relationship	Past & Present Health Problems

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFO

Any release of records or x-rays will be done with separate signed authorization form.

Through the use of this consent form, Knopp Chiropractic is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read and you are hereby encouraged to do so prior to signing this consent.

2. This office reserves the right to change its privacy practices that are described in the privacy practices notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

3. You have a right to request that this office restrict how protected health information is used and/or disclosed to carryout treatment, payment and/or healthcare operations. This office is not required to agree to any restrictions that you have requested.

4. I understand and consent to the following appointment reminders that will be used by Knopp Chiropractic: a.) a postcard mailed to me at the address provided by me; and b.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

5. You have the right to revoke this consent, in writing to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice. I understand that if I am giving this authorization as a condition of obtaining insurance coverage and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

6. I understand that if I revoke this consent at any time, Knopp Chiropractic has the right to refuse treatment

7. I understand this consent is valid for seven years.

****

I _____ acknowledge that I have received the Notice of Privacy Practices and was given an opportunity to have all my questions answered.

Signature:_____ Date:_____

Legal Representative:_____ Relationship_____ Date:_____

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form.

Signature:_____ Date:_____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____ _____

Print Name Relationship

_____

Signature

Cancellation Policy

If you need to cancel your appointment, please call us at 743-2866. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible. You may also respond to your appointment reminder text and or email you receive prior to your appointment.

Beginning January 1, 2020 there will be a $25 fee assessed for all no show appointments.

When you book an appointment, you are holding a space on our schedule that is no longer available to our other patients. In order to be respectful of your fellow patients, please call the office as soon as you know you will not be able to make your appointment.

Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

We appreciate your cooperation in this matter.

Patient
Signature:_____ Date:_____

Name _____

Date _____

PATIENT SECTION

CURRENT CONDITION

1. My pain is a _____ on a scale of zero to ten.
2. I can only lift _____ lbs.
3. I can only walk _____ mile.
4. I can only sit for _____ minutes.
5. I can only stand for _____ minutes
6. I can only read for _____minutes/hours.
7. I have headaches daily/weekly/monthly
8. My headaches are slight/moderate/severe.
9. I can work _____hours per day.
10. I can only drive _____ hour per day.
11. I am sleeping _____ hours per night.
12. I cannot perform these daily chores_____
    _____
    _____
    _____
    _____
    _____.

Knopp Chiropractic
39 Paris St.
Norway, ME 04268

DOCTOR ONLY

TREATMENT GOALS

1. I would like my pain to decrease to a _____ on a scale of zero to ten.
2. I would like to lift _____lbs.
3. I would like to walk _____ mile(s)
4. I would like to sit for _____ minutes.
5. I would like to stand for _____ minutes.
6. I would like to read for _____ minutes/hr.
7. I would like a decrease in headaches.
8. I would like to work _____ hours/day.
9. I would like to drive _____ hour(s) per day.
10. I would like to sleep _____ hours per night.
11. I would like to be able to perform the following daily chores_____
    _____
    _____
    _____
    _____
    _____.

___Reduce swelling
___Reduce Spasms
___Increase Spinal/Joint ROM
___Reduce pain
___Increase Spinal/Joint Strength

Tx plan (30DAYS)

1X/2X/3X WEEK/MTH 1/2/3/4 WKS
1X/2X/3X WEEK/MTH 1/2/3/4 WKS