PRECISION HEALTH GROUP REGISTRATION AND HISTORY

PATIENT INFORMATION

Today's Date: _____

Patient Name:

_____
Last *First* *Middle Initial*

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

In case of an emergency, please contact _____

Relationship: _____ Phone: _____

Patient's E-mail: _____

Birthdate: _____

Sex: ☐ M ☐ F Age: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Spouse's Name: _____

Spouse's Birthdate: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient: _____

Employer: _____

Birthdate: _____

Insurance Company: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, name of insurance company: _____

Subscriber's name: _____

ASSIGNMENT AND RELEASE

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

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

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.

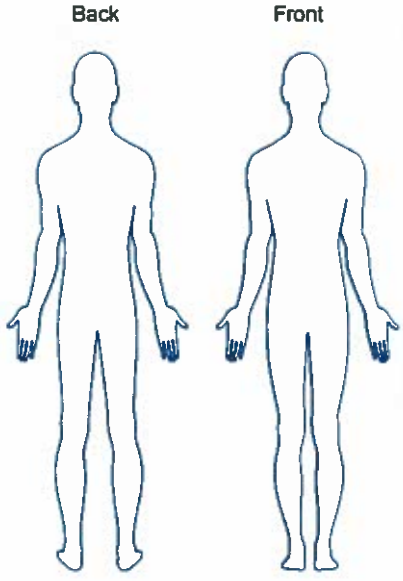
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

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



ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

HEALTH HISTORY

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

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

EXERCISE

- ☐ None
- ☐ 1-2 x/week
- ☐ 3-5 x/week
- ☐ Daily

Type: _____

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day: _____
- ☐ Alcohol — Drinks/Week: _____
- ☐ Coffee/Caffeine Drinks — Cups/Day: _____
- ☐ High Stress Level — Reason: _____

OTHER

PREGNANCY

Are you pregnant? ☐ Yes ☐ No

Due Date: _____

Have you ever been treated for this condition before? ☐ Yes ☐ No

If yes, please list treatments received

Description	Date

SURGERIES

Description	Date

MEDICATIONS

ALLERGIES

Patient Health Information Consent Form
OF
PRECISION HEALTH GROUP

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patients signature Date