REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: □ M □F Age: ____ □ Single □ Married □ Widowed □ Separated □ Divorced

Birthdate: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to **Results Chiropractic, LLC** all medical 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 my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts: _____**
Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Broken Bones: (which and when)_____

Medications: *(please list all medications and supplements that you currently take)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: *(please list all medications that cause allergic reaction)*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery	Date
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma	□ pulmonary embolism	□ respiratory arrest
□ COPD	□ pneumonia	□ sleep apnea
□ emphysema	□ tuberculosis	□ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina	□ high blood pressure	□ irregular heartbeat, arrhythmia
□ heart attack, myocardial infarction	□ heart murmur, valve disorder	□ peripheral vascular disease
□ congestive heart failure	□ mitral valve prolapse	□ deep vein thrombosis
□ other: _____	□ bleeding problems	

Neurologic Disorders

□ stroke or TIA	□ parkinson's	□ cerebral palsy
□ peripheral neuropathy	□ MS	□ polio
□ other: _____		

Bone & Joint Disorders

□ osteoarthritis	□ gout	□ osteomyelitis
□ rheumatoid arthritis	□ lupus	□ ankylosing spondylitis
□ other: _____		

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer	□ diverticulitis	□ hepatitis - Type _____
□ acid reflux, GERD	□ irritable bowel	□ liver disease
□ GI bleed	□ inflammatory bowel disease	
□ other: _____		

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____
Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems
other heart :_____
□ Peripheral neuropathy □ MS or Parkinson's □ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease
hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia
Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare ☐ Auto Accident
☐ Medicaid ☐ Major Medical
☐ BC/BS ☐ Worker's Compensation ☐ Other

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address (if known):
_____

Phone #: _____

LEGAL INFORMATION (Workers Comp / Auto accident):

Attorney Name & Address:
_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate Results Chiropractic, LLC or it's staff as a representative of any agent or entity (private or governmental), or any insurance company or other organizational entity or person.

Signature:_____

Name (printed):_____ Date:_____

Results Chiropractic, LLC
Brian J. Broskoskie, DC
30838 Vines Creek Road, Suite 2A
(P) 302.404.0000

(F) 302.358.2453

MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

1. Your name and address:

_____

_____

2. Phone Number: _____

3. Please describe the collision in your own words:

_____

_____

4. Where did the collision occur?
City/Town: _____State: _____
5. Date of collision: _____ Time: _____ AM PM
6. Were you the: □driver □passenger □pedestrian
7. If passenger, were you in the □front seat □right rear seat □left rear seat
8. What type of vehicle were you in?_____
9. What type was the other vehicle? _____
10. Did your vehicle strike the other vehicle? □yes □no
11. Was your car struck by the other vehicle? □yes □no
12. What direction was your vehicle going? _____
13. What direction was the other vehicle going? _____
14. Was the impact from: □the front □the rear □the left side □the right side
15. What was the approximate speed at the time of the impact?
Your vehicle _____ mph Other vehicle _____ mph
16. What was the weather at the time of the collision? □dry □wet □icy
17. Was your vehicle in: □park □neutral □in gear □moving □stopped
18. Were your brakes being applied? □yes □no
19. Was your vehicle shoved: □forward □backward □sideways
20. Were you shoved: □forward □whipped backward
21. Did your seat have a head restraint (headrest?) □yes □no
22. If yes, what was the position □low □mid-position □high
23. Did your head ride over the headrest? □yes □no

Results Chiropractic, LLC
Brian J. Broskoskie, DC
30838 Vines Creek Road, Suite 2A
(P) 302.404.0000

(F) 302.358.2453

24. Did your hat/glasses end up in the back seat or rear window? □yes □no
25. Did any other part of your body hit the interior of the vehicle? □yes □no
26. If yes, please specify: □seatbelt restraints □steering wheel □dashboard □windshield □side door □side window □other _____
27. Which part of your body? □chest □head □chin □face □R L knee □R L shoulder □R L hand □other _____
28. Were you holding on to the steering wheel? □yes □no
29. Did you brace your arms against the dash? □yes □no
30. Did you brace your legs against the floorboard? □yes □no
31. Was your ankle turned? □yes □no
32. Did the vehicle go into a spin or roll as a result of the impact? □yes □no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? □none □some □a lot
35. How much damage was there to the inside of the vehicle? □none □some □a lot
36. At the point of impact, where did you experience pain? Be specific: _____
37. Immediately after the accident were you: □conscious □dazed □unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? □yes □no
40. Did the belt have a shoulder harness? □yes □no
41. If yes, did it contribute to the pain you are experiencing? □yes □no
42. At the time of impact were you: □looking straight ahead □looking to the right □looking to the left □looking down □looking up
43. Did the seat break as a result of the impact? □yes □no
44. Were you braced for the impact? □yes □no
45. Were you surprised by the impact? □yes □no
46. Did you go to the hospital? □yes □no

Results Chiropractic, LLC
Brian J. Broskoskie, DC
30838 Vines Creek Road, Suite 2A
(P) 302.404.0000

(F) 302.358.2453

47. If yes, when? □right after the accident □next day □other

_____

48. If yes, how did you get there? □ambulance other:

_____

49. If by ambulance, did the ambulance attendants place you in a: □neck brace□back brace □other _____

50. Any medication or medical supplies given?

_____

51. Did you have x-rays taken at the hospital? □yes □no

If you went to the hospital, please answer the following:

Name of hospital

_____

Treatment Received

_____

52. Have you had any similar problems before? □yes □no

53. If yes, explain: _____

54. Are you diabetic? □yes □no

55. Do you have high blood pressure? □yes □no

56. Do you have low blood pressure? □yes □no

57. Do you have arthritis or degenerative joint disease? □yes □no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? □yes □no

61. If yes, give dates:

_____

Patient Signature _____ Date _____

Print Name _____

Results Chiropractic, LLC

Brian J. Broskoskie, DC
30838 Vines Creek Road, Suite 2A
(P) 302.404.0000
(F) 302.358.2453

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by anotherparty involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree with your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised policy as stated in this notice.

Signature of Patient or Legal Guardian: _____Date: _____ _____

Print Name of Patient or Legal Guardian: _____Date: _____ _____