

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

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|--|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack, myocardial infarction | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Gastrointestinal Disorders

- | | | |
|--|---|---|
| <input type="checkbox"/> peptic ulcer or stomach ulcer | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> hepatitis - Type _____ |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> GI bleed | <input type="checkbox"/> inflammatory bowel disease | |
| <input type="checkbox"/> 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

PERSONAL INJURY QUESTIONNAIRE Non- Automobile or Workers Compensation

Please answer all of the following questions completely.

1. Name _____

2. Address _____

City, State, Zip _____

3. Phone Number: Home _____ Work _____

4. Please describe the injury in your own words:

5. Was there anything in particular that you think caused the injury: example: wet floor

Please Describe _____

6. Where did the injury occur? _____

7. City/Town: _____ State: _____ Telephone # _____

8. Date of injury: _____ Time: _____ AM PM

9. Did anyone witness your injury? Yes No Who? _____

10. Did you report the injury to anyone Yes No To Whom? _____

11. Was the report written verbal

12. Have you retained an attorney No

13. If Yes, please give name and address: _____

14. Immediately after the injury were you: conscious dazed unconscious

15. If you lost consciousness, how long? _____

Did you go to the hospital? Yes No

16. If yes, when? right after the injury next day other _____

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment Received _____

17. If yes, how did you get there? ambulance other: _____

18. If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other _____

19. Was any medication or medical supplies given? Yes No If yes, list:

20. Did you have x-rays taken at the hospital? Yes No

21. Are you diabetic? Yes No

22. Do you have high blood pressure? Yes No

23. Do you have arthritis or degenerative joint disease? Yes No

24. List all prescription and non prescription medications you take on a regular basis:

25. Are you presently under treatment for any condition? Yes No _____

26. Who is your primary care doctor: name, address and phone: _____

27. Do You Smoke? Yes No Drink Alcohol? Yes No

28. Did you have any physical complaints **Just before the injury**? Yes No

29. If yes, what physical symptoms did you have **just before the injury**? _____

30. What type of work do you do? _____

31. What are your job requirements? _____

32. Have you lost any days of work because of this injury? Yes No

33. If yes, give dates: _____

ACTIVITIES OF DAILY LIVING

34. Do you notice any of your **HOME** activities that are different **now** than they were **before** the injury? NO / YES If yes, please list: (please be very specific)

Those activities that you are now unable to do are: _____

Those activities that are now painful to do are: _____

Those activities that are now difficult to do are: _____

Is there anything else we should know? _____

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 another party 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: _____