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

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: _____ _____