# 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

# WORKER'S COMPENSATION QUESTIONNAIRE

**Please answer all questions completely and return to the office.**

Employee's name & address: _____

_____

_____

Phone number: _____
Occupation: _____
Age: _____ Sex: Male____ Female____

Employer's name & address: _____

_____

_____

Phone number: _____
Type of business (retail, manufacturing, construction, etc.): _____

_____

Worker's Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ AM / PM
What address were you at when you were injured?_____

_____

Did you notify your employer of this injury? Circle one, YES / NO
Have you retained an attorney? YES / NO
If yes, please give name & address: _____

_____

Are you currently in litigation for this injury? YES / NO / MAYBE
Please explain how the injury or illness occurred: _____

_____

_____

What injuries did you suffer? _____

_____

When was the last date you worked? _____
When did you return to work? _____

When was your first examination? _____
Who examined you? _____ Circle one, if known DC / MD / DO / DDS
What was the doctor's diagnosis?_____
_____
Have you received any treatments prior to visiting this office? YES / NO
What treatments did you receive?_____
_____
Have you ever injured this area before? YES / NO
If yes, when did the injury occur? _____
Did you lose time from work? YES / NO
If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted:
_____
_____
_____
Do you have other injuries or illnesses that affect your employment? YES / NO
If yes, please explain: _____
_____
Do you have a history of absenteeism caused from accidents on the job? YES / NO
Have you ever had a Worker's Compensation claim before? YES / NO
Before the injury were you capable of working on an equal basis with others your age? YES / NO
Are your work activities restricted as a result of this accident? YES / NO
Since this injury are your symptoms IMPROVING? / GETTING WORSE? / THE SAME?

Signature:_____

Name: (Printed)_____ Date:_____

# Results Chiropractic, LLC

**Brian J. Broskoskie, DC**
30838 Vines Creek Road, Suite 2A
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(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: _____ _____