CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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

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-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

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

5 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) _____

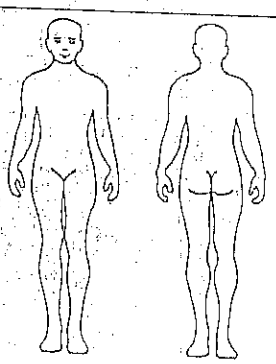
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

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

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

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

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

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

PATIENT NAME_____AGE_____DATE_____

List foods you love.

List foods you dislike.

List foods you usually eat for breakfast.

List liquids you usually drink for breakfast.

List snacks and beverages you have at mid-morning.

List foods you usually eat for lunch.

List liquids you usually drink for lunch.

List snacks and beverages you have at mid-afternoon.

List foods you usually eat for dinner.

List liquids you usually drink for dinner.

List before or after dinner alcoholic drinks you usually have.

List snacks and liquids you usually have in the evening between dinner and bed-time.

What do you usually eat or drink at bed-time?

HOW MANY TIMES A WEEK DO YOU EAT IN RESTUARANTS ?

The Neck's Generation

Thyroid Genealogy

MY MEDICAL HISTORY

To help your doctor, please print out this form. Fill in completely and take it to your doctor on your next visit.

Please note in your family tree if your family members have had any of the following conditions which are associated with thyroid disease. People with these conditions may be more at risk for developing thyroid disease:

- Diabetes
- Anemia
- Arthritis
- Other autoimmune disorders
- Pituitary or endocrine diseases

Maternal Grandparent:

Medical History:

Maternal Grandparent:

Medical History:

Paternal Grandparent:

Medical History:

Paternal Grandparent:

Medical History:

Parent:

Medical History:

Parent:

Medical History:

My Name:

Medical History:

Sibling:

Medical History:

Sibling:

Medical History:

Sibling:

Medical History:

Child:

Medical History:

Child:

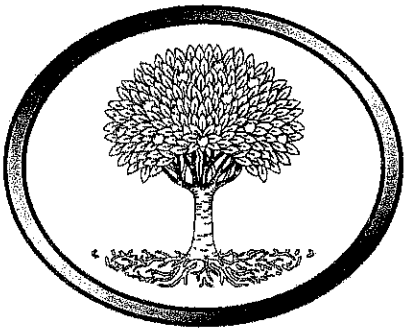
Medical History:

Child:

Medical History:

Child:

Medical History:



Moon Family Health Center

Non-Covered Service Disclosure

Nutritional consultations and laboratory tests are considered non-covered services in our office. I have been notified prior to receiving the aforementioned service and understand fees are payable directly to Moon Family Health Center at the time of service.

Patient (print)_____Date_____

Patient (signature)_____

Rev. 4/04

Insurance Information for Moon Family Health Center

Our insurance personnel will complete the claim form for you and send it to your company. It is your responsibility to provide us with your current insurance card and claims address.

It is your responsibility to pay the specific percentage or co-pay that your insurance does not cover You will be expected to pay in full at the time services are rendered if you have not met your deductible. If your insurance company deems a particular service as non-covered or not medically necessary in their judgment, payment will need to be made by you. You, the insured, will have far greater success in encouraging the insurance company to fulfill their obligation.

Our office will wait 45 days for payment from your insurance carrier. If for some reason they are slow we would require you to pay your bill within 60 days from the date of service.

All unpaid charges are turned in for collection 90 days from the date of treatment.

If your current condition is due to an automobile accident, we will need your auto insurance card and claim number for the accident in order to send in your claim.

If you current condition is due to an injury incurred while you were at work then we will need your employers permission to treat you. Please inform the front desk staff if you have not already done so.

Reminder: We have your best interest at heart. We make every effort to obtain accurate and up to date information regarding insurance contracts and coverage. In this complicated insurance environment, we (the provider) are not necessarily given accurate information. We will not be held responsible for these discrepancies. We will make every effort for reimbursement but remember, that the insurance companies' responsibility is to you, and your responsibility is your bill with us.

Nutrition: Consultations and laboratory testing is usually considered a "non-covered" service by most insurance companies and as such it is necessary to pay at the time of these services.

Medicare: Medicare will cover office visits only after your deductible has been met. Examination, x-rays, nutritional supplements and therapy are not covered by Medicare and are not counted toward your deductible therefore you are responsible for those costs if the doctor deems them necessary. Your condition may require, in our judgment, different or additional, treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be sent for review and we cannot guarantee or predict what the review board will decide in your case. Medicare will pay 80% of the allowable recognized charges. **We do not accept Medicare assignment.** This means that Medicare will send the check to you in payment of services they cover. This also means that you are solely responsible for payment for services at the time they are rendered. Due to certain information required by Medicare our office will prepare and send your claim directly to Medicare.

Patient agrees to pay all charges incurred as a result of any visit to or care rendered by G. R. Moon D.C., P.A. within 90 days from the date of treatment. In the event that said charges are not paid within 90 days of treatment, Patient agrees to pay all costs, fees and expenses, including all reasonable attorney's fees, incurred as a result of any effort to collect said charges.

Patient:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Moon Family Health Center
1190 Pine Ridge Road
Suite 1
Naples, FL. 34108

I understand that under the Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____
Relationship to Patient _____
Signature _____
Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____
Initials _____
Reason _____