

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) _____

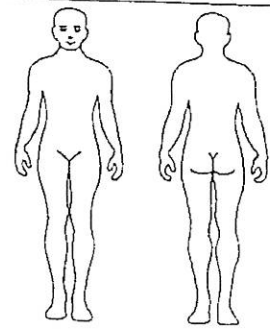
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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



Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____

Date: _____

Preferred Language?

- English
- Spanish
- Other _____

Race?

- I do not wish to provide this information.
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other _____

Ethnicity?

- I do not wish to provide this information.
- Hispanic or Latino
- Non-Hispanic or Non-Latino
- Other _____

Smoking Status?

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Do you have any medication allergies?

- No known medication allergies
- Yes. What? _____

Are you currently taking any medications?

- Not currently prescribed any medications
- Yes...
 - What? _____ mg
 - What? _____ mg
 - What? _____ mg

Office Use Only

- 1
- 2-5
- >5

WILTSE et. al.

Patient #: _____

PAIN DRAWING

Name: _____

Today's Date: _____

Date of Birth: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>
>>>>

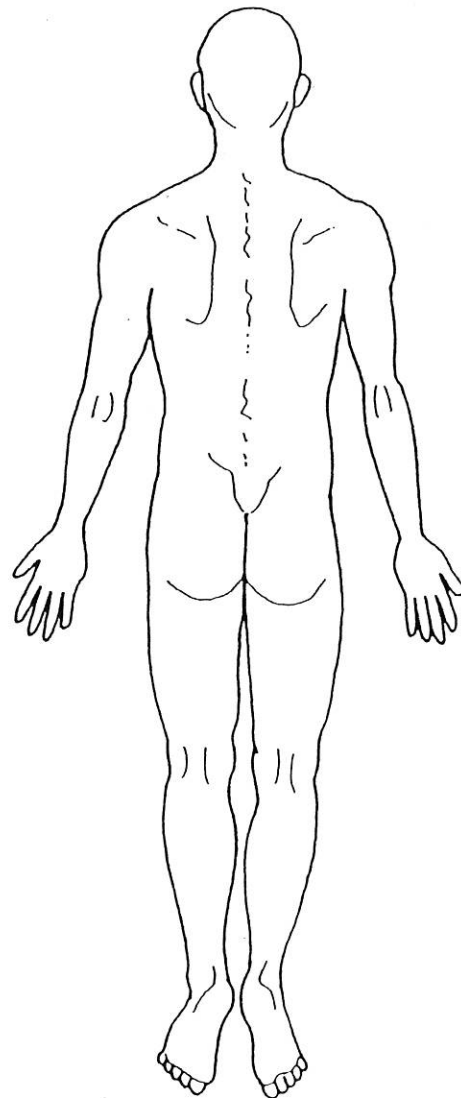
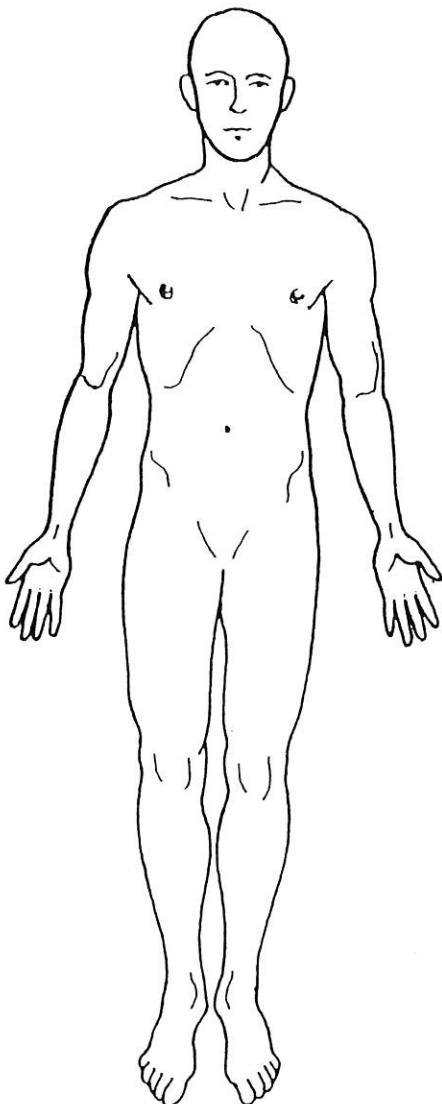
Numbness =====
=====

Pins and Needles o o o o
o o o o

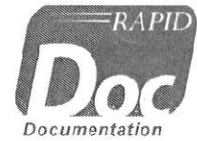
Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~



INITIAL EVALUATION – Non Accident Related



LAST NAME: _____ FIRST NAME: _____ MI: _____ Date: _____

What brings you into our office? **Not accident related**

Do you feel your condition is: Improving Staying the same Getting worse

Have you lost time from work? Yes No

Can you perform physical work activities? Yes No

If no, because of: Pain Weakness Stress

Can you go to sleep without problems? Yes No

Do you awaken because of pain? Yes No

Did you have sleep problems before? Yes No

Activities of Daily Living

Please select all activities which you are currently experiencing problems:

- | | | | | | |
|------------------------------------|--|-------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Tasting | <input type="checkbox"/> Smelling | <input type="checkbox"/> Eating | <input type="checkbox"/> Hearing | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Reading | <input type="checkbox"/> Typing | <input type="checkbox"/> Writing | <input type="checkbox"/> Grasping | <input type="checkbox"/> Using the toilet |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Leaning | <input type="checkbox"/> Walking | <input type="checkbox"/> Stooping | <input type="checkbox"/> Squatting | <input type="checkbox"/> Loss of sexual drive |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting | <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Restful sleeping |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving | <input type="checkbox"/> Sports | <input type="checkbox"/> Exercising | <input type="checkbox"/> Reclining | <input type="checkbox"/> Loss of concentration |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Riding in car | <input type="checkbox"/> Air travel | <input type="checkbox"/> Climbing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Changes in personality |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Pinching | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Reaching | <input type="checkbox"/> Nervous | <input type="checkbox"/> Tactile feeling |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Holding | | | | |

INITIAL EVALUATION – Non Accident Related



Past Medical History

Please select all conditions that you have had or are currently having:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis, Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver / Gallbladder Problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular in coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or foot | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness joints | <input type="checkbox"/> Thyroid disease of |
| <input type="checkbox"/> Tinnitus/ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Wrist pain | | | | |

INITIAL EVALUATION – Non Accident Related

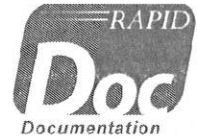


Family History

Please select all conditions that run in your family:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight Gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis,
Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty
swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent
urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HBP | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular
menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver/Gallbladder
problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder
control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular
coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or
foot | <input type="checkbox"/> Pain in lower leg
or knee |
| <input type="checkbox"/> Pain in upper
arm or elbow | <input type="checkbox"/> Pain in upper leg
and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual
flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal Dx | <input type="checkbox"/> Rheumatoid
arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness
of joints | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tinnitus/
ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual
disturbances |
| <input type="checkbox"/> Wrist pain | | | | |

INITIAL EVALUATION – Non Accident Related



Surgical History

Please select all surgeries that you have had in the past.

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal
Exploration | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> ACL
Reconstruction | <input type="checkbox"/> Adenoid Removal | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bone Fracture
Repair |
| <input type="checkbox"/> Breast Lump
Removal | <input type="checkbox"/> Bunion Removal | <input type="checkbox"/> Carotid Artery
Surgery | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Cervical Spine
Surgery |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Cosmetic Breast
Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Facelift | <input type="checkbox"/> Gallbladder
Removal |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemorrhoid
Surgery | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Hip Joint
Replacement | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney
Transplant | <input type="checkbox"/> Knee
Arthroscopy | <input type="checkbox"/> Knee Joint
Replacement |
| <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> LASIK Eye Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lumbar Spine
Surgery | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Prostate
Removal | <input type="checkbox"/> Rotator Cuff Surgery | <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Vasectomy |
- Surgical History was reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

- | | | | | |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Antacids | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Daily Vitamins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion | <input type="checkbox"/> Heart | <input type="checkbox"/> Muscle Relaxers | |
| <input type="checkbox"/> OTC | <input type="checkbox"/> Pain | <input type="checkbox"/> Steroids | <input type="checkbox"/> Thyroid | |

Allergies

Please select all items that you are allergic to:

- | | | | |
|-------------------------------|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Chemical | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medication | <input type="checkbox"/> Seasonal | |

Social History

Please answer the following questions:

- Married Single Widowed Divorced Separated
- Do you have any children? Yes No If yes, how many? _____
- Do you use: Tobacco Alcohol Coffee

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 your 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 Health 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 _____