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) _____

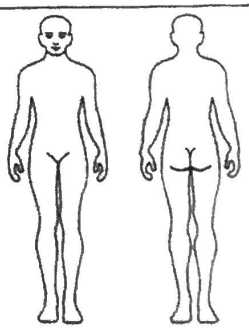
5 PATIENT CONDITION

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

_____

_____

_____

_____

_____

HAVLICEK
CHIROPRACTIC

PATIENT EHR UPDATE

please print

NAME:_____DOB:_____ DATE:_____
EMAIL:_____CELL #_____

RACE: _____ Alaskan Native ___American Indian ___Asian _____White
_____ Black/African American_____Native Hawaiian_____Other Pacific Islander_____Decline to State

ETHNICITY: _____Decline to State_____Hispanic or Latin____Not Hispanic or Latin

SMOKING: _____Never Smoked____Past Smoker____Presently Smoking
_____# packs a day.

MEDICATIONS: (name and dosage) _____
_____
_____
_____
_____

ALLERGIES:_____

INSURANCE COMPANY (if applicable) _____

Weight_____ Height _____ Blood Pressure _____

FAMILY HISTORY
FATHER Living age ____ Deceased age ____
_____Diabetes _____ Cancer_____High Cholesterol _____Back Problems
_____Heart Disease _____High Blood Pressure_____ Other_____
_____

MOTHER Living _____ Deceased age ____
_____Diabetes_____Cancer_____High Cholesterol_____Back Problems
_____Heart Disease_____High Blood Pressure_____Other_____
_____

HAVLICEK CHIROPRACTIC
Dr. Bradley M. Havlicek
2085 A1A South, Suite 103
St. Augustine, FL 32080

General Pain Index Questionnaire

We would like to know how much your pain **presently** prevents you for doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

*Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.*

1. Family / At-home responsibilities such as yard work, chores around the house or driving the kids to school –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending other social functions –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. Employment inducing volunteer work and homemaking tasks –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. Self-Care such as taking a shower, driving or getting dressed –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. Life-Support activities such as eating and sleeping –

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Patient Name: _____ **Date:** _____

Score: _____ (60)

BRADLEY HAVLICEK, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I consent to have chiropractic adjustments and possibly other chiropractic procedures including various modalities, and x-rays (only after speaking to the doctor if they are necessary) to be performed by a chiropractic physician working in this office.

I will have an opportunity to discuss with our doctor the purpose of chiropractic care and procedures. I wish to rely upon the doctors judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him is in my best interest.

I further understand the Chiropractic adjustment and supportive treatment is designed to reduce and/or correct subluxation allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hope to avoid more invasive procedures.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also involve some level of risk. The risks are rare and may include but not limited to: sprain/strain injuries, muscle and joint soreness, fractures, dislocations, disc injuries, stroke, muscle spasms for a short period of time. I do not expect the doctor to be able to anticipate and explain all risks and complications. I also realize that I have other options for treatment other then chiropractic care.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and by signing below I agree to and consent to physical examination, chiropractic adjustments and other chiropractic modalities, when necessary. I intend this consent form to cover the entire course of my present condition and any future condition (s) for which I seek treatment.

_____ printed name

_____ signature

_____ date

WITNESS:

_____ printed name

_____ signature

_____ date

CONSENT TO TREAT MINOR-FOR USE WHEN APPLICABLE

I hereby authorize the Chiropractic doctors of this facility, to administer chiropractic, as deemed necessary, to my child.

_____ name of child

_____ (signature (parent or guardian)

_____ date

HAVLICEK CHIROPRACTIC
2085 A1A SOUTH, SUITE 103
ST. AUGUSTINE, FL 32080
904-515-2225

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered to see a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____

Patient Name (please print) Date

_____

Signature

_____

Parent, Guardian or Patient's
Legal Representative

Havlicek Chiropractic maintains a confidentiality policy with all patients' medical information. Please list the names of those that you give this office permission to speak with concerning your medical condition.

I _____ hereby give permission for this office to give information regarding my medical condition to the following:

_____

_____

_____

_____ _____

Signature of Patient Date

HAVLICEK CHIROPRACTIC
Dr. Bradley M. Havlicek
2085 A1A South, Suite 103
St. Augustine, FL 32080
Phone: 904-515-2225, Fax: 904-515-2235

FINANCIAL POLICY FOR HAVLICEK CHIROPRACTIC

Thank you for choosing our office for your care. Your health is very important to us.

INSURANCE

All co-payments and deductibles must be paid at the time of service. I participate in most insurance plans. If you are not insured by a plan I participate with, payment is expected at each visit until we are able to verify your insurance coverage. We will gladly file with your insurance, but knowing your insurance coverage is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE

I am a participating Medicare provider. However, that does not mean that all services are covered.

MEDICARE ONLY COVERS NECESSARY SPINAL ADJUSTMENTS. It does not cover x-rays, modalities, massage, MRI, etc. It does not cover MAINTENANCE CARE. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments to your particular policy.

SELF PAY

Payment in full is due at the time of service if you do not have insurance.

CLAIM SUBMISSION

We will gladly submit your claims and assist you in any way we reasonably can to help get your claims paid. If we participate with your insurance, we will file insurance before billing you. Your insurance is a contract between you and your insurance company.

PATIENT BILLING

You will receive a notice for your financial responsibility (co-insurance, deductible) after payment or explanation of benefits (EOB) is received from your insurance company/companies. We accept the following payment methods: cash, check or credit card. Please let us know if you are having difficulties resolving your bill. In the event your insurance company should happen to send payment to you, the patient, we expect that you will forward it to our office to be applied to your balance.

I have read the Financial Policy and have agreed to the same.

_____
Patient Name, Please Print

_____ _____
Signature of Patient/ Parent or Legal Guardian Date

Havlicek Chiropractic, Inc.
2085 A1A South, Suite 103
St. Augustine, FL 32080

Insurance Assignment and Instruction for Direct Payment

I, (PRINT NAME)_____, hereby instruct and direct my insurance company pursuant to F.S. 627.422 to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services. And any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment is to not exceed my indebtedness to the above named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, Motor Vehicle Insurance, Personal Injury Protection (PIP), Disability, or any other Health or Medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above named provider.

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check payable to me and mail it to the office indicated above.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I also agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for services in full at the time services are rendered. Ultimately, payment responsibility rests with you the patient.

I also authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above named provider to file any informal complaints that are necessary to the Insurance Commissioner's Office or agency or court they deem appropriate on my behalf.

_____ _____
Signature of Patient (Claimant) Date

_____ _____
Witness/Guardian (if minor)____ Date