Family Chiropractic
Ron Wilcox, D.C.

Patient Registration

204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

First Name:______________________ MI: ___ Last Name:______________________
DOB: ___/___/_____ Age: _____ Gender: ❑ Male ❑ Female SSN: ______________
Name Suffix: ❑ Jr. ❑ Sr. *(If applicable)*

Address 1: ______________________ Address 2: ______________________
City: ______________________ State: __________ Zip Code: __________
Home Phone: ______________________ Mobile Phone: ______________________
Work Phone: ______________________
Preferred Communication: ❑ Phone ❑ Mail/Letter ❑ Email ❑ Patient Portal ❑ Fax ❑ Decline
Confidential Communications: ❑ Home ❑ Work ❑ Mobile ❑ Email ❑ Patient Portal ❑ Mail ❑ Decline
Personal Email: ______________________________________

How would you like to receive appointment reminders?
❑Text Message ❑Email ❑I choose to decline appointment reminders.

Marital Status: ❑ Single ❑ Married ❑ Other
Employment Status: ❑ Employed ❑ FT Student ❑ PT Student ❑ Retired ❑ Self Employed ❑ Other
Professional Title: ______________________ Employer: ______________________
Employer Address: ______________________ City:__________ State:________ Zip: ________
Emergency Contact: ______________________ Relationship to Patient: ______________
Home Phone: ______________________ Mobile Phone: ______________________

Who is your Primary Care Physician? ______________________________
Practice name? ______________________________

Whom may we thank for referring you? ______________________________
Can we send them a thank you note for referring you to us? Yes or No

Patient Demographics:

Race: *(check one or more)* ❑ White ❑ American Indian/Alaskan Native ❑ Black/African American
❑ Native Hawaiian or other Pacific Island ❑ Asian ❑ Decline
Ethnicity: *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline
Preferred Language: *(list)*______________________ ❑ Decline

Smoking: *(check one)* ❑ Current Sometimes Smoker ❑ Never Smoker ❑ Smoker, Current Status Unknown
❑ Unknown if Ever Smoked ❑ Heavy Smoker ❑ Light Smoker
❑ Current Every day Smoker: What is the frequency that you smoke? _____ Packs/Day
❑ Former Smoker: Smoking End Date: __________ ❑ Decline

Exercise: *(check one)* ❑ None ❑ Moderate ❑ Daily ❑ Heavy
Work Activity: *(check one)* ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor
Habits: *(check one)* ❑ Alcohol: Drinks/week _____ ❑ Coffee/Caffeine: Cups/day _____ ❑ High Stress Level
Female: Are you pregnant? ❑No ❑ Yes, Due Date: ________ Last Pelvic Exam: ______________

Briefly list your main health problems:
1. ______
2. ______
3. ______
4. ______
5. ______

List any known allergies:
1. ______
2. ______
3. ______
4. ______
5. ______

Do you carry an Epipen? ☐ Yes ☐ No

Current Prescribed Medications: **Vitamins/Supplements, include dosage if known:**

Name:	Dosage:	Name:	Dosage:
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Do you have a personal or family history of diabetes, heart problems, high blood pressure or other systemic illnesses?
______
______

Injuries/Surgeries you have had:
Fall: ______ Description: ______ Date: ______
Head Injuries: ______ Description: ______ Date: ______
Broken Bones: ______ Description: ______ Date: ______
Dislocations: ______ Description: ______ Date: ______
Surgeries: ______ Description: ______ Date: ______

Please check to indicate if you have/had any of the following:

☐AIDS/HIV
☐Alcoholism
☐Allergy Shots
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding Disorders
☐Breast Lump
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependency
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heart Disease
☐Hepatitis
☐Hernia
☐Herniated Disk
☐Herpes
☐High Cholesterol
☐Kidney Disease
☐Liver Disease
☐Measles
☐Migraine Headaches
☐Miscarriage
☐Mononucleosis
☐Multiple Sclerosis
☐Mumps ☐Osteoporosis
☐Pacemaker
☐Parkinson's Disease
☐Pinched Nerve
☐Pneumonia
☐Polio
☐Prostate Problems
☐Prosthesis
☐Psychiatric Care
☐Rheumatoid Arthritis
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Tumors
☐Typhoid Fever
☐Ulcers
☐Venereal Disease
☐Whooping Cough

☐Other: ______

What is your main concern for today's visit?
______
How did this start? ______
Is the pain: ☐ Better ☐ Worse ☐ About the Same
When did it start? ______
Is the pain constant? ☐Yes ☐No If not, when is it worse? ______
What makes the pain worse? ______
What makes the pain better? ______
What treatment have you received? ______
Have you seen a Chiropractor before? ☐ Yes ☐ No
If yes, who? ______ How long ago? ______

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key:

Numbness
- - - - - - -

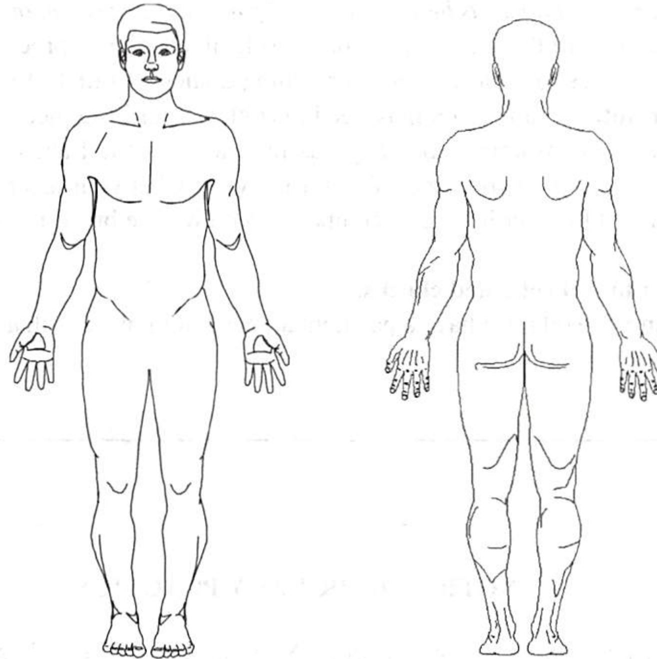
Pins and Needles
oooooooo

Burning
xxxxxxxx

Stabbing/Sharp
///////////////

Aching/Dull
****

Popping/Clicking
P P P



INFORMED CONSENT

A patient, in coming to Family Chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment/massage or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or provide health care, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic x-rays on me (or for the patient for whom I am legally responsible) by Family Chiropractic and/or by other licensed Doctors of Chiropractic who now or in the future will treat me while employed by, working with, or associated with Family Chiropractic.

Signature of the Patient Date

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT/CONTRACT

I hereby authorize Family Chiropractic to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Family Chiropractic. I hereby agree to full responsibility for all expenses incurred by myself, or dependent(s).

Signature of the Patient Date

FINANCIAL POLICY AND AGREEMENT

1. Insurance co-payments and co-insurance are required at check out. Patients who have no insurance are required to abide by the Self-Pay Policy. We accept cash, check and Visa, Discover, Master Card, American Express.
2. *Unless required by a provider contract, we bill your insurance company as a service for you. If you have a private insurance, please remember that the insurance contract is between you and your insurance company, not between the insurance company and this office.* We are not a party to that contract. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance or demographics. **Your bill is your responsibility, whether your insurance company pays or not.** At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. If your insurance company has not paid your full account within 90 days you must pay the outstanding balance without delay. You are responsible for knowing what your insurance does and does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.
3. **A $30.00 fee will be charged for all returned checks.**
4. All bills/balances greater than $100.00 must have a payment agreement in place with a credit/debit card on file for automatic payment.

____

Signature of the Patient | Date

NOTICE OF PRIVACY PRACTICE

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at 360-352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

____

Patient/Legal Representative Signature | Date

____

Printed Name if signed on behalf of patient | Relationship

DISCLOSURES TO FAMILY AND/OR FRIENDS DOCUMENTATION FORM

Family Members/Friends Involved in my care: (HIPPA)

1) I agree that this office may disclose my private health information to only the following individuals listed below.
2) Allow them financial information.
3) Allow them the ability to schedule and cancel appointments.

____

Name | Relationship

____

Name | Relationship

____

Name | Relationship

____

Signature of the Patient | Date