# 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) _____

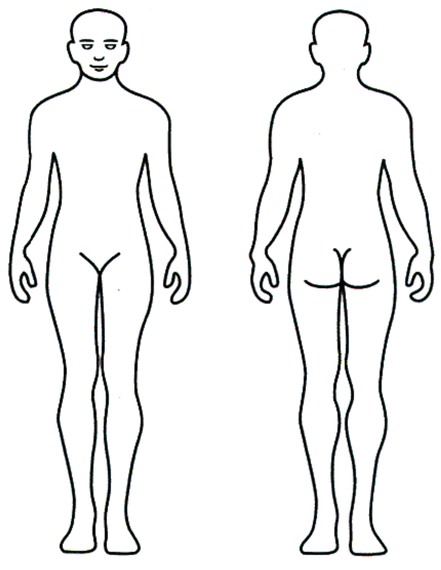
## 5 PATIENT CONDITION

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 | | | High Cholesterol | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No | Other _____ | | |
| Dependency | ☐ Yes | ☐ No | 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

Lifestyle Wellness Center
"Change Your Lifestyle, Change Your Life"
Family & Sports Chiropractic

# ***FINANCIAL POLICIES:***

**PAYMENT FOR SERVICE**
Unless prior arrangements have been made, services are to be paid for on the date they are rendered.
Our office accepts credit/debit, cash and checks, however any NSF checks returned will be assessed a $30 fee and we will no longer be able to accept check payment from that individual.

**INSURANCE PROCEDURE**
As a courtesy to you, we will file your claim with your insurance company and wait for their payment on your account. As you know, the health industry is changing everyday and they are looking for every possible way to cut their costs. The filing and follow-up process costs us time and money and does not remove you from the following responsibilities:

1. Knowing what your insurance policy will and will not cover;
2. Knowing the amount of your deductible or co-pay (Remember-most deductibles do not rollover to the next year, and start over in January);
3. Reading your Explanation of Benefits (EOB) so that you are aware of what is and is not being paid.

Other than contractual adjustments between Dr. Weinzetl and your insurance company, **you are responsible for all charges your insurance company does not pay within 90 days.** If a claim is denied twice, you are then responsible for the payment. Please notify us if you change insurance companies.

**AUTO INSURANCE**
If you are receiving Personal Injury Protection (PIP) coverage from an auto accident, you are responsible for letting us know any other charges if any other charges have been submitted against your claim.

If the insurance check is sent to you, please bring it to our office within the week. **Once again, you are responsible for all charges your insurance does not pay for within 90 days**.

If you have any questions regarding your bill, our charges, or any financial arrangements, please feel free to contact us at any time.

## AUTHORIZATION ASSIGNMENT & RELEASE FORM

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to Dr. Chad Weinzetl as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
**I have read and agree to follow the above financial policies and assignment of benefits.**

PATIENT SIGNATURE_____DATE_____

**4140 Legacy Drive, Ste. 324 Plano, TX 75024 Phone: 469-241-9665**
**www.chirochangeslives.com**


# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature Date

Lifestyle Wellness Center
"Change Your Lifestyle, Change Your Life"
Family & Sports Chiropractic

# CONSENT TO X-RAY

I hereby authorize Lifestyle Wellness Center and whomever Dr. Chad Weinzetl may designate as his assistants to take x-rays of myself (or said minor).

Dated this _____day of _____, 20_____.

_____
Printed Name

_____
Signature

_____
Parent/Guardian Signature (if a minor)

## Pregnancy Release

Date of onset or last menstrual period (LMP):_____.

I hereby state that I am not pregnant and therefore, release Lifestyle Wellness Center from any and all liability.

Dated this _____ day of _____, 20_____.

_____
Patient Printed Name

_____
Patient Signature

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# INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to Lifestyle Wellness Center, gives Dr. Weinzetl permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Dr. Weinzetl, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of Dr. Weinzetl. Dr.Weinzetl provides a specialized, non-duplicating health care service. Your 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 understand that if I am accepted as a patient by Dr. Weinzetl at Lifestyle Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if a minor):_____

**4140 Legacy Drive, Suite 324 Plano, TX 75024 Phone (469)-241-9665**

www.chirochangeslives.com

Lifestyle Wellness Center

*Family & Sports Chiropractic*

## Credit Card Authorization Form

Please complete all the fields below.

| **Credit Card Information** | | | |
|---|---|---|---|
| Card Type: ☐ MasterCard | ☐ VISA | ☐ Discover | ☐ AMEX |
| ☐ Other _____ | | | |
| Cardholder Name (as shown on card): _____ | | | |
| Card Number: _____ | | | |
| Expiration Date (mm/yy): _____ | | | |
| Cardholder ZIP Code (from credit card billing address): _____ | | | |

I, _____, authorize Lifestyle Wellness Center to charge my credit card above for the $20 cancellation fee for any missed appointments without a 24 hour notice. We also will use this card to charge any outstanding balances. We will notify you before we charge your card. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Signature Date

4140 Legacy Dr. Suite 324 Plano, TX 75024 Phone: (469) 241-9665 Fax: (469) 241-9224

www.chirochangeslives.com

# WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

## Let's get started

Please check any that apply to you:

### Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

### Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

### Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

### Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

### Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

### Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

### Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

### Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

### Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

| | None | Mild | Mod | Severe |
|---|---|---|---|---|
| Constipation and/or diarrhea | 0 | 1 | 2 | 3 |
| Abdominal pain or bloating | 0 | 1 | 2 | 3 |
| Mucous or blood in stool | 0 | 1 | 2 | 3 |
| Joint pain or swelling, arthritis | 0 | 1 | 2 | 3 |
| Chronic or frequent fatigue or tiredness | 0 | 1 | 2 | 3 |
| Food allergies, sensitivities or intolerance | 0 | 1 | 2 | 3 |
| Sinus or nasal congestion | 0 | 1 | 2 | 3 |
| Chronic or frequent inflammations | 0 | 1 | 2 | 3 |
| Eczema, skin rashes or hives (urticaria) | 0 | 1 | 2 | 3 |

| | None | Mild | Mod | Severe |
|---|---|---|---|---|
| Asthma, Hayfever, or airborne allergies | 0 | 1 | 2 | 3 |
| Confusion, poor memory or mood swings | 0 | 1 | 2 | 3 |
| Use of NSAIDS (Aspirin, Tylenol, Motrin) | 0 | 1 | 2 | 3 |
| History of antibiotic use | 0 | 1 | 2 | 3 |
| Alcohol consumption makes you feel sick | 0 | 1 | 2 | 3 |
| Gluten sensitivity or Celiac's disease | 0 | 1 | 2 | 3 |
| Nausea | 0 | 1 | 2 | 3 |
| Weight issues | 0 | 1 | 2 | 3 |

**YOUR TOTAL** _____