Oakville Health and Rehab Center Patient Registration

Patient Information

Name: _____ *Date:* _____ *Age:* _____
Address: _____ *City:* _____ *State:* _____ *Zip:* _____
Phone :(H) _____ *(C)* _____ *Email:* _____
Date of Birth: _____ *Sex: M F Marital Status: S M D W # of Children*
Past chiropractic care? Y N When? _____ *Doctors Name:* _____
Occupation: _____ *Employer:* _____
Emergency Contact: _____ *Relationship:* _____ *Phone:* _____
How were you referred to our office? _____

Medical and Legal Information

Are your present problems due to an auto accident, work related injury, or other personal injury someone else may be legally liable for? Yes No If yes, please notify the front desk now.
Pregnant? Y N Pacemaker? Y N Family Physician: _____

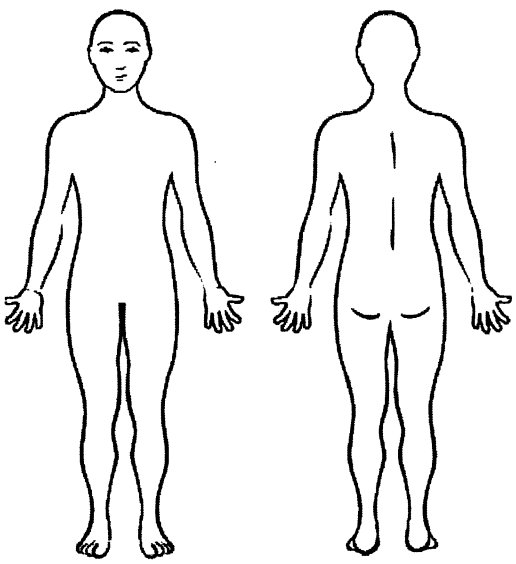
What is your primary reason for today's visit?

_____

Please list the area(s) in which you experience pain symptoms in order of severity:
1) _____ *Began (Mo./Yr.):* _____ *Past Episodes* _____
2) _____ *Began (Mo./Yr.):* _____ *Past Episodes* _____
3) _____ *Began (Mo./Yr.):* _____ *Past Episodes* _____
What is the intensity of your pain today on a scale of 0 to 10 where 0 is no pain at all? _____
What positions make it feel worse? _____ *Better?* _____
Does this condition interfere with your: Work Sleep Daily Routine Other _____
What do you think caused this condition? _____

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain and include all affected areas. You may draw on the face as well.

Aches ^^^^ *Burning* xxxx
Numbness oooo *Stabbing* ////
Pins/Needles ••••



Medical History

Please check conditions or symptoms you currently have or have had in the past:

__AIDS/HIV	__Cancer	__Heart Disease	__High Cholesterol	__Pacemaker
__Anemia	__Chemical Dependency	__Hepatitis	__Jaw Pain/TMJ	__Pinched Nerve
__Appendicitis		__Hernia	__Kidney Disease	__Pneumonia
__Asthma	__Diabetes	__Herniated Disk	__Liver Disease	__Rheumatoid Arthritis
__Blood Clots	__Emphysema	__Herpes	__Multiple Sclerosis	
__Breast Lump	__Goiter	__High Blood Pressure	__Osteoporosis	__Thyroid Problems
__Bronchitis	__Gout			

Please list any surgical procedures you have had and the year in which they took place:

_____

_____

Are your vaccinations up to date? __Y__N

List any fractures or broken bones: _____

List medications, dosage, and frequency: _____

List any health hazards you are exposed to at home/work, such as toxic chemicals, dust, fumes, etc: _____

List areas of your body, if any, which suffer from arthritis: _____

How often, if ever, do you suffer from headaches? _____

Do you have persistent stomach pain, indigestion, or trouble with bowel movements, such as constipation or diarrhea? __Y__N If yes, please describe: _____

Is your stress level: __low __medium __high

List any dietary preferences/restrictions: _____

Please check symptoms that you suffer from:

__Irritability
__Difficulty in concentrating
__Mood Swings
__Dizziness, trembling, palpitations
__Brain fog/loss of mental acuity
__Concerns about your weight
__Anxiety, sadness, and depression for which there is no situational explanation
__Inexplicable drops in your strength stamina at various times of the day

*Exercise: Type of exercise*_____ *Minutes per day:* _____ *Times per week:* _____

Tobacco: #pks/day currently: ____ *#pks/day in the past:* ____ *How long ago did you quit?* ____

Caffeine: cups of coffee drank/day: ____ *cups of tea drank/day:* ___ *cups of soda drank/day:* ___

Alcohol: Type of alcohol: _____ *Amount per week:* _____

Family History

Please write the relationship of any family member who has suffered from or is currently suffering from conditions relating to the following:

Diabetes: _____ *Kidney conditions:* _____

Heart conditions: _____ *Cancer:* _____

Please list any other conditions that run in your family: _____

INSURANCE DISCLAIMER

In the recent past, we have had several mishaps with insurance companies quoting wrong benefit coverage information for co-pays and/or deductibles. Unfortunately, when we call for benefits, the insurance companies state, **"THIS QUOTE IS NOT A GUARANTEE OF BENEFITS."** *Therefore, since your insurance coverage is a contract between you and your insurance company,* **WE HIGHLY RECOMMEND THAT YOU ALSO CALL TO VERIFY YOUR BENEFIT COVERAGE FOR CHIROPRACTIC CARE.** *This will help eliminate any future confusion. Otherwise, when we receive the explanation of benefits (usually 2-4 weeks from date of service), we will then rectify any misquotes/discrepancies...i.e. payments or refunds between you and Oakville Health and Rehab Center.*

I fully understand that I am directly and fully responsible to said doctor(s) for all chiropractic bills submitted for services rendered to me for deductible/co-pay/co-insurance/ or uncovered services per my contract with the insurance company.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The doctor's office will prepare reports and forms necessary to assist me in filing of my claim with the insurance company. Direct payments made from the insurance company to the doctor's office will be credited to my account upon receipt and any balances due will be my responsibility.

All services rendered to me are my personal responsibility and I agree to make payment for these services to the doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

Signature: _____ *Date:* _____

I, as a parent/guardian of the patient, give complete authorization for this patient to be x-rayed and undergo treatment as necessary for their treatment plan.

Parent/Guardian Signature: _____ *Date:* _____

Patient Health Information Consent Form (HIPPA)

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 healthcare operations, we must require that you read and sign this consent form stating that you understand and agree to 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 that you read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. *The patient understands and agrees to allow Oakville Health and Rehab Center to used their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and the coordination of care. As an example, the patient allows this chiropractic office to submit requested PHI to the patient's health insurance company/companies provided to us by the patient for payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company/companies require for payment.*

2. *The patient has the right to examine and obtain a copy of his/her health records at any time and require corrections if needed. The patient may request to know what disclosures have been made and submit in writing and further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.*

3. *A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.*

4. *The patient may provide a written request to revoke any consent at any time during care. This would not affect 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 members have 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 available to those who do not need them.*

6. *Patients have the right to file a formal complain with our privacy official about any possible violation of these policies and procedures.*

7. *If the patient refuses to sign this consent form for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give the patient care.*

I have read and understand how my Patient Health Information (PHI) will be used, and I agree to these policies and procedures state above.

Patient Signature *Date*

Oakville Health and Rehab Center
Dr. Ronald V. Arconati, D.C.
Dr. Michael W. Hines, D.C.

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain presently prevents you from 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/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 including 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:* _____

Total Score: _____