Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		City/State/Zip:	
Email Address:			
Home Phone:	Cell Phone:	Cell Phone Provider: ☐ AT&T ☐Sprint ☐Verizon ☐ Other_____	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only **One** Option) ☐ Voice ☐ Text ☐ Email		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician: Phone #:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender	
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:		
Employer Name: Work Phone #:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

How did you hear about our office? ☐ Facebook ☐ Instagram ☐ Google search ☐ Website ☐ Family/Friend
Other:

Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred **Pharmacy** Name, Phone # and Location:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Atlantic Coast Physical Medicine's (ACPM) / Atlantic Coast Integrative Medicine's (ACIM) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to ACPM / ACIM all money to which I am entitled for medical expenses related to the services performed from time to time by ACPM / ACIM, but not to exceed my indebtedness to ACPM / ACIM. I authorize ACPM / ACIM to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from ACPM / ACIM by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the ACPM / ACIM Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to ACPM / ACIM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of ACPM / ACIM's Privacy Notice. A copy of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request.

(Initials) ☐

Signature of Responsible Party: X_____**Date**_____

Printed Name of Responsible Party X_____**Date**_____

Consent for Treatment

I hereby request and consent to outpatient care and chiropractic care from Atlantic Coast Physical Medicine / Atlantic Coast Integrative Medicine (ACPM / ACIM) encompassing routine diagnostic procedures, examinations, chiropractic adjustments and medical treatment including but not limited to routine lab work, physical rehab, manual manipulation and administration of medication as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by ACPM / ACIM medical providers and staff, as is necessary in the medical staff's judgement.

I have had an opportunity to discuss with the Provider(s) and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other treatments and procedures. I understand that results are not guaranteed.

I understand and am informed that, that in the practice of medicine and in the practice of chiropractic care there are some risks to treatment, diagnostic services and rehab exercises, including but not limited to:

Manipulation: Increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and Procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs (X-Rays): ionizing radiation can be harmful to a fetus for those who are pregnant or may be pregnant.

I do not expect the medical provider(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the provider(s) to exercise judgment during the course of treatment/ procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Waiver and Release: I hereby release and discharge and acquit ACPM/ACIM, its agents, representatives, affiliates, employees, or assigns, of any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, emergency medical technician, physician or urgent care services.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

This form is a consent form and general release of medical liability for the diagnosis, care and/or treatment by ACPM / ACIM. By signing this form, I am agreeing not to hold ACPM/ ACIM or its staff liable for any complications that may arise during the course of treatment.

Patient/ Guardian Signature*_____ Date _____

Relationship (if not patient) _____

Witness Signature _____ Date_____

*If this Consent for Treatment is signed by someone other than the patient, it must be signed in the patient's presence

Patient Name_____Date_____

CURRENT MEDICATION	DOSAGE	Times per day

Supplements or Herbal Medication	DOSAGE	Times per day

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.): ☐ Yes ☐ No

Motrin or Aspirin: ☐ Yes ☐ No

Tylenol: ☐ Yes ☐ No

Acid blocking Drugs (Tagamet, Zantac, Prilosec): ☐ Yes ☐ No

Frequent or long-term use of Antibiotics: ☐ Yes ☐ No How often:_____

Steroids (Prednisone, Nasal Allergy inhalers): ☐ Yes ☐ No

Allergies: Do you have allergies to medications or other substances? (Pets, food, molds, glutens, etc)

If yes, please list allergy and reaction (including, rash, hives, throat swelling, anaphylaxis):

ALLERGY	REACTION

Doctor's Signature _____

Patient Name_____Date_____

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ High Blood Pressure	□ Stroke/CVA/TIA	□ Skin Disorder	□ Stroke/ CVA/ TIA
□ Thyroid Disease	□ Fibromyalgia	□ Kidney Disease	□ Osteoporosis
□ Seizures	□ COPD	□ Asthma	□ Depression
□ Metal Implants	□ Headaches / Migraines	□ Psychiatric Illness	□ Anxiety

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar Spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic Spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia

□Breast Augmentation Other _____

Social History: (Circle all that apply to you)

Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Drink Water: □<64 oz/day □>64 oz/day □ never
Tobacco: □<1 pack/day □ >1 pack/day □ never
Sleep: □<8 hours/night □ >=8 hours/night □ Insomnia
Recreational Drugs: □ occasional □ often □ never Type/method_____
Other _____

Injuries: (Circle all that apply)

□ Back Injury □ Head Injury □ Neck Injury □ Soft Tissue □ Broken Bones/Fractures □ Industrial
□ Severe Fall □ Other_____
Describe treatment and outcome: _____
_____

Family History: (Circle all that apply)

Arthritis:	□ Parent	□ Sibling	Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Heart Disease:	□ Parent	□ Sibling
Hypertension:	□ Parent	□ Sibling	Stroke:	□ Parent	□ Sibling
Thyroid:	□ Parent	□ Sibling	Psychiatric Disorders:	□ Parent	□ Sibling
Auto Immune Disease:	□ Parent	□ Sibling	Other: _____		

Occupational Activities: (Circle one that best describes your job description)

□ Administration	□ Business Owner/Executive	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Manufacturing	□ Home Services	□ Manual Labor
□ Housekeeper	□ Manual Labor-Heavy/Medium/light	□ Other _____	

Physical Activity: (Circle all that best describes your daily activities) □ Inactive □ Light □ Moderate □ Heavy

□ Bending	□ Climbing	□ Kneeling	□ Pulling	□ Pushing	□ Reaching	□ Twisting
□ Sitting	□ Standing	□ Repetitive	□ Computer			

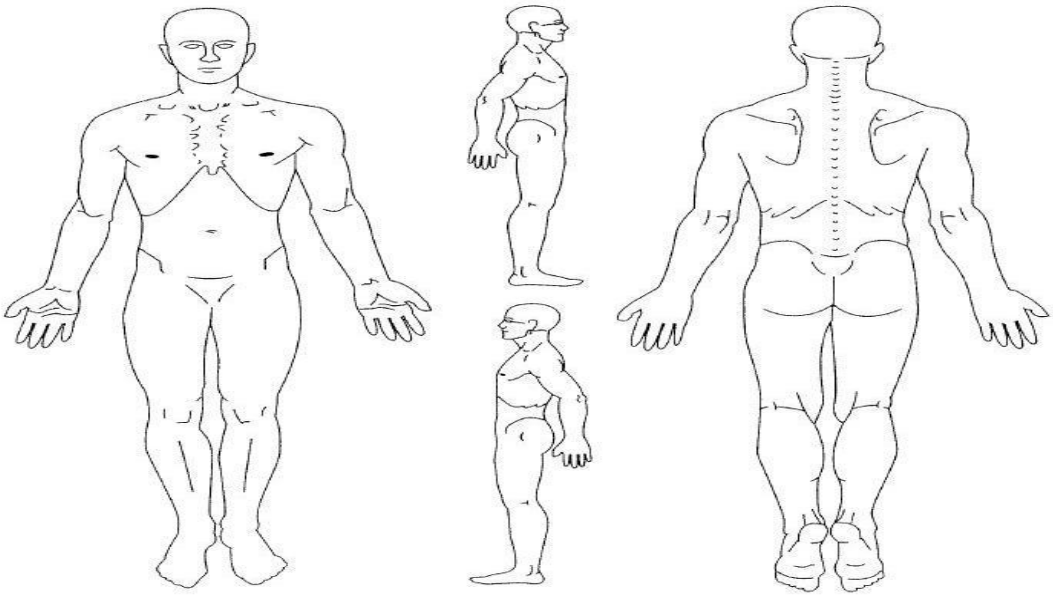
Are You Pregnant? (Check) ☐ **Yes** ☐ **No**

Doctor's Signature _____

Patient Name_____**Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**_____

When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work Related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp □ Ache □ Numb □ Shooting

□ Burning □ Tingling □ Throbbing □ Other _____

What effect does your current condition have on your DAILY activities?

□ No effect □ Slightly limited □ Limited □ Mostly limited □ Unable to Perform

What daily activities are effected:_____

Doctor's Signature _____

Modified Oswestry Low Back Pain Disability Questionnaire[a] Name:_____ Date:_____

This questionnaire has been designed to give your Provider information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I can manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself, and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want, but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2 hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Please complete questionnaire on other side.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under 1/2 hour.
- ☐ My pain prevents all travel except for visits to the physician / therapist or hospital.

Employment / Homemaking

- ☐ My normal homemaking / job activities do not cause pain.
- ☐ My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

FOR OFFICE USE ONLY

Score: /50 x 100 =____% points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 10%points (Change of less than this amount may be attributed to error in the measurement.)

Name:_____ **Date:** _____

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy*. 2001;81:776-788.

[a]Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy*. 1980;66:271-273.

Modified Oswestry Neck Pain Disability Questionnaire[a] Name:_____ Date:_____

This questionnaire has been designed to give your Provider information as to how your neck pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care (e.g., Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself, and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Reading
- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of moderate pain in my neck.
- ☐ I cannot read at all.

Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Concentration
- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want.
- ☐ I have a lot of difficulty in concentrating when I want.
- ☐ I have a great deal of difficulty in concentrating when I want.
- ☐ I cannot concentrate at all.

Work
- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Please complete questionnaire on other side.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Recreation

- ☐ I am able to engage in all of my recreation activities with no pain in my neck.
- ☐ I am able to engage in all of my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreation activities because of pain in my neck.
- ☐ I am able to engage in only a few of my recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

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Patient Name_____Date_____

PAYMENT POLICY

Thank you for choosing Atlantic Coast Physical Medicine/Atlantic Coast Integrative Medicine (ACPM/ACIM) as your chiropractic and Integrative Medical provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE: We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit or you can enter into a payment plan agreement. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your benefits.
2. CO-PAYMENT AND DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE: All patients must complete patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. PAYMENT RESPONSIBILITY: You understand and agree that regardless of whatever health insurance or medical benefits you have, You are ultimately responsible to pay ACPM/ACIM the balance due on your account for any professional services rendered and for any supplies, tests or medications provided.
6. ASSIGNMENT OF BENEFITS: You hereby authorize payment of, and assign your rights to, any health insurance or medial plan benefits directly to ACPM/ACIM for any and all medical/healthcare services, supplies, tests, treatments and/or medication that have been or will be rendered or provided.
7. COVERAGE CHANGES: If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
8. MISSED APPOINTMENT: Our policy is to charge $35.00 for missed appointments not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

_____ _____

Printed Name of patient or responsible party **Date**