HARDISON FAMILY CHIRPORACTIC

PATIENT REGISTRATION

Dr. Mr. Mrs. Ms. Patient: (full legal name)_____

Preferred name: _____

Mailing Address: _____ City:_____ State:___ Zip:_____

Phone: (___)_____ Cell:_____Texting OK ? Y / N

Email: _____ Martial Status: Single Married Divorced Widowed

Date Of Birth: _____/_____/_____ Sex: Male Female Social Security #: _____-_____-_____

Patient Employer/School:_____ Occupation: _____

Medical Insurance Provider: _____

Primary Policyholder: _____ Relationship to Patient: _____

Guarantor Date Of Birth: _____

Emergency Contact: _____ Relationship to Patient: _____

Whom should we thank for referring you to our practice? Internet/Groupon Drove by Yellow Pages

Insurance Company Family/Friend: _____

Have you ever been to a chiropractor before? If yes, whom did you see? _____

I agree that the information supplied is accurate to the best of my knowledge. I authorize Dr. Todd A. Hardison, Hardison Family Chiropractic at my request, to file and release to any insurance company I may choose, any information necessary to process a claim for benefits. I understand that verification of my insurance benefits via phone/internet is *not* a guarantee of payment. I understand I am responsible for any unpaid balances not paid by my insurance. Any outstanding balances over 90 days past due will be turned over to collections for further collection procedures. A copy of this may be used in place of the original.

Signature:_____ Date:____/____/____

HARDISON FAMILY CHIRPORACTIC

What is the reason for today's visit? _____

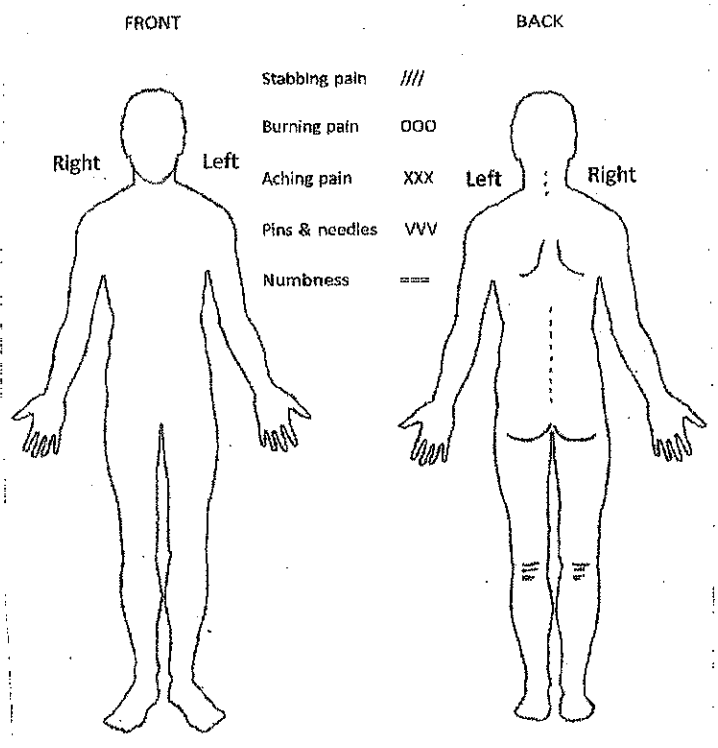
_____

How long have you had these symptoms? _____
Did you have an injury? _____
If yes, describe the injury: _____

_____

Have you had similar problems before? _____

Draw your pain on the diagrams shown. Use the corresponding symbols to show the



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

1 2 3 4 5 6 7 8 9 10

extreme pain

How would you describe the symptoms (dull, sharp, etc.)? _____

_____

What makes the pain better (rest, ice, heat)? _____
What makes the pain worse (reaching overhead, bending, etc)? _____

_____

What treatment have you had so far? _____

_____

NAME _____ **DATE** _____

DATE OF LAST PHYSICAL ____/____/____ DATE OF LAST EYE EXAM ____/____/____

LIST **ANY MEDICATIONS** YOU CURRENTLY TAKE (RX OR OVER-THE-COUNTER) _____

_____

Do you have **ALLERGIES** to any medications? YES NO

If YES, list the medications: _____

List all major illnesses (diabetes, high blood pressure, heart attack, stroke, etc) or injuries (concussions):

_____

List any major surgeries: _____

Do you currently have any problems in the following areas? **If YES, please give details:**

REGION/CIRCLE ALL THAT APPLY	YES	NO	DETAILS
EYES (eye pain, tearing, redness, discharge, glare, headache, change in vision, floaters, ocular trauma, double vision, difficulty driving, flashes of light, eyelid swelling, eye strain, loss of vision)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss/gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuff nose, earache, cough, dry mouth)			
CARDIOVASCULAR (high BP, racing pulse)			
RESPIRATORY (congestion, wheezing, short of breath)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcer)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice)			
FEMALES: Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis)			
SKIN (acne, warts, growths, rash)			
NEUROLOGICAL (numbness, headache, seizures, paralysis)			
ENDOCRINE (diabetes, hypothyroid)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, HIV, Hepatitis C)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling, Cousin)**

Has any member of you family had these diseases? (Circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other inheritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Do you drink alcohol? YES NO IF YES, how much? _____

Do you smoke? YES NO IF YES, how much? _____ How many years? _____

Signature _____ **Date** _____

Consent to Treat

I, _____, hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Todd A. Hardison and/or other licensed doctors of chiropractic who now or in the future are employed at Hardison Family Chiropractic.

I have had an opportunity to discuss with Dr. Todd A. Hardison and/or with other office staff the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest.

Printed Name:_____ Relationship to Patient: _____

Signature:_____ Date:____/____/____

HARDISON FAMILY CHIRPORACTIC CANELLATION/NO-SHOW POLICY

Here at Hardison Family Chiropractic we strive to provide the highest quality service to all of our patients. We are always happy to try to schedule appointments to accommodate your busy schedule. However, if you are unable to keep an appointment, we ask that you give us a 24 hour notice. Making your appointment as scheduled is very important, not just for us, but for yourself as well. Appointment times are in demand and a missed appointment is not only lost revenue for us, but time that someone else could have used.

If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 24 hours in advance. If you cancel your appointment without a 24 hour notice or if you fail to show up for your appointment time, a $25 charge will be applied to your account. Hardison Family Chiropractic also reserves the right to cease rescheduling appointments due to habitual no-shows or cancellations.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy allows us to better schedule our patient's appointments at times that are convenient for them and is fair for everyone.

Thank you for your consideration on this matter and we look forward to your appointment time with us.

I have read the above and understanding on this cancellation/no-show policy of Hardison Family Chiropractic.

_____ _____

Patient/Guardian Signature Date