REGISTRATION

**Confidential Patient Information**

BACKSMITH CHIROPRACTIC, Lucas J. Smith, DC, DACBSP
1878 East Wyandot Ave, Suite A1, Upper Sandusky, OH 43351
Phone (419)731-4229 Fax (419)731-4157

Patient Name:_____ Chief Complaint:_____

Address:_____ Home Phone:_____
City:_____ Zip:_____ Cell Phone:_____
SS#:_____ Email:_____
Date of Birth:_____ Marital Status: M S W D
Occupation:_____ Employer:_____
Address of Insured (if different than above):_____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ____Yes ____No

Insurance Company:_____ Insurance Phone #:_____
ID#_____ Group #_____
Name of Policy Holder_____ Policy Holder DOB_____
Policy Holder Employer_____

Family Physician_____ ( May we send your health information to this provider Y / N )

Person to Contact in case of emergency (Name & Phone)_____

Have you ever been under Chiropractic care? Y / N If so, who?_____

Have you had: X-RAY / MRI / CT in the last year? If so, where?_____

What operations have you had?_____When?_____

Serious Illness/Infectious Disease:_____When?_____

Do you have a pacemaker? Y / N Do you have any Shoulder, Hip, Knee Replacements? Y / N _____

What medications are you taking? ___Pain Killers ___Insulin ___Cholesterol ___Blood Pressure ___Muscle Relaxers ___Birth Control Other:_____

What is your goal in our office?_____

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care coverage with the above captioned, and hereby assign at physician's request, and convey directly to Dr. Smith, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor any and all plan documents, insurance policies and/or settlement information upon written request from such doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor against such insurers and/or employee health care plan in my name but at such doctor expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as original. I have read and understand this agreement.

_____ _____
Signature of Insured/Guardian Date

CASE HISTORY

| This box will be completed by our Office Staff: | HT:_____ WT:_____lbs.<br>BP_____ /_____ PR _____bpm |
|---|---|

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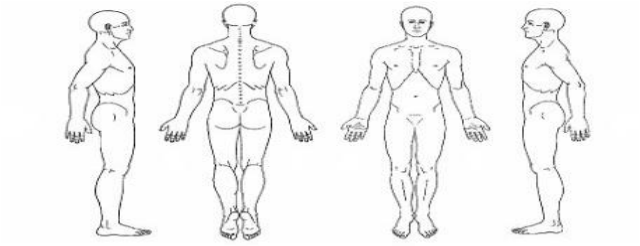
1. **Please List your condition** **Circle the Severity of Pain** **Circle the Frequency of Pain**

| Condition/Problem | Severity (Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe) | Frequency (% of time) (Occasional 10 20 30 40 50 60 70 80 90 100 Constant) |
|---|---|---|
| a. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 10 20 30 40 50 60 70 80 90 100 |
| b. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 10 20 30 40 50 60 70 80 90 100 |
| c. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 10 20 30 40 50 60 70 80 90 100 |
| d. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 10 20 30 40 50 60 70 80 90 100 |

2. Symptoms are worse in the: **(Circle what applies)**

- Morning - Increase during the day
- Afternoon - Same all day
- Night -Decrease during the day

**Please mark the regions of pain**



3. Describe your Symptom: **(Circle what applies)**

Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. When did your symptoms begin (onset date)? _____
5. How did your symptoms begin? _____
6. Has your condition: ____ Improved ____ Worsened ____ Stayed the same
7. Have you ever experienced this before? ____Yes ____No
8. Do your symptoms radiate? ____Yes ____No
9. What makes your condition worse: **(Circle what applies)**

Bending / Lifting / Movement / Running / Standing / Sitting / Sleeping / Twisting / Walking / Working

10. Does anything relieve the pain? ___Yes ___ No Describe: _____
11. If No, what have you tried? _____
12. Have you been treated for this before? ___Yes ___No How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____ Good ____ Poor Comments _____
15. Were you referred to our office by anyone? _____
16. List any major Injuries or Surgeries: _____
17. List any Medications or Supplements you are taking: _____
18. Any other Musculoskeletal Problems ___Yes ____No …Neurological Problems ____Yes ____No

_____ Additional Information on the back

I certify the above information is accurate to the best of my knowledge.

Signature _____ Date _____

# TERMS OF ACCEPTANCE

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The goal of our office is to enable patients to gain control of their health.

To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other 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. The doctor, of course, will not give any treatment or 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 healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor 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 regimen. I understand that if I am accepted as a patient by Dr. Lucas Smith, I am authorizing him to proceed with any treatment he deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge: _____ **I am** **_____ am NOT** pregnant.

Consent to Evaluate & Treat a Minor:

I, _____, being the parent of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communication:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse:_____ Phone:_____

Children:_____ Phone:_____

Others: _____ Phone:_____

Do not communicate my information with anyone. _____

May we leave messages regarding your healthcare information on any answering devices, such as home answering machines or voicemails? _____Yes _____No

May we contact you via email? _____Yes _____No

Acknowledgement:

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Print Name: _____

Signature: _____ Date: _____