Patient Registration Form

Last Name:_____ First Name:_____M.I.:_____

SS:_____-_____-_____ DOB:_____ Male/Female

Cell#:_____Home#:_____Email: _____

Address:_____City:_____Zip:_____

Circle one: Single Married Divorced Widow

Who referred you to our office: _____

Were you referred to a certain doctor? _____

Is this visit due to an Auto Accident? Yes/No Work Related Injury? Yes/No

Major Complaints

Briefly describe your symptoms:_____

_____

Employer

Employer Name:_____ Employer Phone #:_____

Address:_____ City:_____ Zip:_____

Occupation:_____

If Student Name of School: _____

Spouse Information

Last Name:_____ First Name:_____M.I:_____

SS:_____-_____-_____ DOB: _____ Male / Female

Please complete if patient is a Minor

Name of Father:_____ DOB:_____ SS#:_____

Name of Mother:_____ DOB:_____ SS#:_____

In case of an Emergency Contact:

Name:_____Relationship:_____Phone#:_____

Signature:_____ Date: _____

CATER CHIROPRACTIC

Formulario de Registro de Pacientes

Apellido:_____ Nombre:_____M.I.:_____

SS:_____-_____-_____ Fecha de Nacimiento:_____Hombre/Mujer

Tel#:_____Cell#:_____Correo Electrónico:_____

Dirección:_____Ciudad:_____Código Postal:_____

Marque uno: Soltero/a Casado/a Divorciado/a Viudo/a

Quien lo/la refirió a nuestra oficina:_____

¿Fue referido a un cierto doctor?_____

¿Es esta visita debido a un accidente de auto? Si/ No ¿Lesión del trabajo? Si/No

Quejas Principales

Brevemente describa sus síntomas:_____

_____

Empleado

Nombre de empleador:_____ Teléfono#:_____

Dirección:_____Ciudad:_____Código Postal:_____

Ocupación:_____

Si es estudiante, Nombre de escuela:_____

Información del cónyuge

Apellido:_____ Nombre:_____M.I.:_____

SS:_____-_____-_____ Fecha de Nacimiento:_____Hombre/Mujer

Por favor complete esta parte si el paciente es menor de edad

Nombre del Padre:_____ FDN:_____ SS#:_____

Nombre de la Madre:_____ FDN:_____ SS#:_____

Contacto en caso de una emergencia

Nombre Completo:_____Rel.:_____teléfono#_____

Firma:_____ Fecha:_____

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Financial Policy

CASH Patients

- We request that 100% of the first visit be paid at the time of your first visit. We accept cash, check or Visa/ MasterCard/ American Express/ Discover credit cards.
- For subsequent visits, it is our policy that if you are unable to pay at the time of each visit, that payment arrangements be made. This keeps your account current.
- All nutritional and orthopedic supports must be paid for at the time you purchase them.
- Exceptions to the above rule must be prearranged with the office manager.

Patient signature _____Date_____

Política financiera

Pacientes sin seguro

- Solicitamos que el 100 % de la primera visita se pagará en el momento de su primera visita. Aceptamos efectivo, cheque o tarjeta de crédito Visa / MasterCard / American Express / Discover.
- Para las visitas posteriores, nuestra política es que, si usted no puede pagar en el momento de cada visita, que pueden hacer arreglos de pago. Esto mantiene su cuenta corriente.
- Todos los soportes ortopédicos y nutricionales deben ser pagados en el momento de comprarlos.
- Las excepciones a la regla anterior deben ser solicitadas con el gerente de la oficina.

Firma de paciente _____ Fecha_____


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Privacy Notice Form

This notice describes how chiropractic medical information about you may be used, how it may be disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Cater Chiropractic we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another party, such as an insurance carrier, an HMO, PPO, or your employer, if they are responsible for the payment for your services.

*Your name, address, phone number, and your health case records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest of you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communication with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of our protected health information, other than as outlined above, will be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information in a different form, please advise us in writing as to your preference.

Privacy notice continued and signature line on back →

CATER CHIROPRACTIC

Privacy notice form continued

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend our health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of our patient file and protected health information therein. We are also required to provide you with this notice of our private practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice if changes are made to our privacy notice we will notify in writing as soon as possible following the chances, any changes I our privacy notice will apply for all of your health information in our files.

Information that we disclose based on this privacy notice may be subject to re disclosure by the person to whom we proved the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: **Dr. Gregory H, Cater D.C**

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of the patients and staff. this environment is used for ongoing care and this is NOT the environment for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private confidential setting. The use if this format is intended to make you experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name Printed: _____

Signature: _____ Date: _____

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures/examinations including various models of physical therapy and diagnostic x-ray. On me (or by the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who are now, or may be employed in the future, treat me at this clinic. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but no limited to fractures, disc injuries, strokes, dislocations, sprains and burns. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors then known, is in my best interest.

The probability of these risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between on in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the -counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers.
- Hospitalization/Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the information of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient's Signature: _____ Date: _____

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Consentimiento informado

Yo solicito y doy consentimiento para la realización de los ajustes quiroprácticos y otros procedimientos quiroprácticos / exámenes, incluyendo varios modelos de terapia física y de diagnóstico por rayos x en mí (o por el paciente mencionado, por el cual yo soy legalmente responsable) por el médico quiropráctico mencionado a continuación y/u otros médicos con licencia de la quiropráctica que están, o que estarán empleados en el futuro, me tratan en esta clínica. Yo entiendo que los resultados no están garantizados.

Yo entiendo y estoy informado de que, como en la práctica de la medicina, en la práctica quiropráctica, hay algunos riesgos de tratamiento, incluyendo, pero no limitado a fracturas, lesiones de disco, accidente cerebrovascular, luxaciones, esguinces y quemaduras. No espero que el médico anticipe y/o explique todos los riesgos y complicaciones. Deseo confiar en el médico para ejercer juicio en el curso del procedimiento que el médico sienta en ese momento, sobre la base de todos los factores conocidos hasta entonces, es en mi mejor interés.

La probabilidad que estos riesgos se produzcan: Las fracturas son ocurrencias raras y generalmente son el resultado de alguna debilidad subyacente del hueso, que revisamos durante la toma de su historia y durante el examen y rayos x. Accidente cerebrovascular ha sido objeto de gran desacuerdo. La incidencias de accidente cerebrovascular son muy poco frecuentes y se estima que ocurren entre el encendido en un millón y uno de cada cinco millones de ajustes cervicales. Las otras complicaciones también se describen generalmente como raras.

La disponibilidad y la naturaleza de otras opciones de tratamiento

Otras opciones de tratamiento para su condición pueden incluir:

- autoadministrado, analgésicos de venta libre y reposo
- Atención médica y los medicamentos recetados tales como antiinflamatorios, relajantes musculares y analgésicos.
- Hospitalización / Cirugía

Si opta por utilizar una de las opciones anteriores señaladas "otros tratamientos", debe tener en cuenta que existen riesgos y beneficios de tales opciones y es posible que desee hablar sobre esto con su médico primario.

El asistente de riesgos y peligros de permanecer sin tratar: Lo que queda sin tratar puede permitir la formación de las adherencias y reduce la movilidad, que podrá constituir una reacción de dolor reduciendo aún más la movilidad. Con el tiempo, este proceso puede complicar el tratamiento por lo que es más difícil y menos eficaz cuanto más tiempo se pospone.

Firma del paciente: _____Date: _____

Exam:
Xray:

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Consultation Form

Name:_____ Date:_____
Referral:_____ Dr: _____
History of complaint:_____
_____
_____
_____
_____

( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____
Detail:_____
Radiation:_____
What aggravates:_____What alleviates:_____
( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____
Detail:_____
Radiation:_____
What aggravates:_____ What alleviates:_____
( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____
Detail:_____
Radiation:_____
What aggravates:_____What alleviates: _____
( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____
Detail:_____
Radiation:_____
What aggravates:_____What alleviate:_____

Other Symptoms:_____
TX/X-Rays Received: _____
Chiro TX:_____
Medication/Supports:_____
Limitations on ADL's:_____
Exercise:_____Cardio:_____Wt.Lifting:_____Other:_____
Diet: Good/Average/Not Good Vitamins/Nutrients:_____
Type of work_____

In the past 6 months, have you had any of the following?

Headaches: Y/N_____
Dif. Sleeping:: Y/N_____
Dizziness: Y/N_____
Loss of Energy: Y/N_____
Blurred Vision: Y/N_____
Tired in the A.M:Y/N_____
Loss of Concen: Y/N_____
Buzz/Ring Ear: Y/N_____
Depression: Y/N_____
RunDown: Y/N_____
Nervousness: Y/N_____
Faint/Palpitation:Y/N_____

In the past 6 months have you had any of these general problems?

Sinus: Y/N_____
Kidney/Bladder: Y/N_____
C/S PN/Stiffness: Y/N_____
Colon/Constipation: Y/N_____
Shoulder (R or L): Y/N_____
Low Back: Y/N_____
Arm/Hand/(R or L): Y/N_____
Hip (R or L): Y/N_____
UB/MB/Ribs: Y/N_____
Leg Pain(R or L): Y/N_____
Chest Pains: Y/N_____
Poor Circ.: Y/N_____
Lung/Heart: Y/N_____
Stomach/Digestion:Y/N_____
Gall Bladder/Liver Y/N_____
Other:_____

Previous Pertinent Medical History:

Hospital/Surgery: Yes/No:_____

_____

Accidents (MVA/Falls) Yes/No:_____

_____

Job Accidents (Open/Closed) None:_____

_____

Meds Taken for any Condition:_____
Allergies:_____
Family History of back problems:_____
Other: _____

_____

_____

_____

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Patient Information

Patient Number: _____ Date: _____

Last Name:_____First Name:_____DOB:_____Age:_____ M/F

Email:_____Referred By:_____

Thank you date:_____ Report Dates 1. _____2._____3._____

Presenting Complaints:

1. _____/10 2. _____/10 3. _____/10

4. _____/10 5. _____/10 6. _____/10

X-Ray Findings: Views Taken: _____

_____

_____

_____

_____

Onset:_____**Diagnosis:** _____

_____

_____

_____

TX Recommendations: Chiro:_____

_____

Disability Status:_____

_____Re Exam:_____

Therapy: IF IST Myofascial Class IV Laser Ice Massage

Recommended Exercises: Back:_____ Neck:_____

EXT EX: _____ General /Exercise: _____

Current Diet/Vitamins: _____

Recommended Nutrition:_____

Home Care Recommendations: _____

Denneroll: _____

Insurance Summary:

%	Exam	X-Rays	OV's	DED	MET	Amt to Ded	Copay	TX