PATIENT REGISTRATION FORM

Manhattan Sports Medicine AND WELLNESS GROUP

Date of Appointment: _____

Part 1: Patient Information

Patient's First Name	Middle Name	Last Name

Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Date of Birth	Age	Social Security Number

Patient's Address	Apt. No.	City	State	ZIP

Home Phone No.	Mobile Phone No.	Work Phone No.	Email Address

Employer / School	Occupation	Employer / School Phone

Employer / School Address	City	State	ZIP

Emergency Contact Name	Emergency Contact Phone No.	Relation to Patient

Part 2: Billing and Insurance

Insurance Company	ID Number (see insurance card)	Group Number (see card)

If Patient is the Insurance Policy holder, you may skip to Part 3

Insured's Name / Policy holder (as it appears on card)	Insured's Employer / School

Insured's Address	City	State	ZIP

Insured's Phone No.	Relation to Patient	Insured's Date of Birth	Insured's Social Security No.

Part 3:

Main Complaint ☐ Left ☐ Right

Other Complaints ☐ Left ☐ Right

How did you hear about our office?	Referring Doctor / Person

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INSURANCE CARRIER **PPO / HMO** **Pre-Authorization Y / N**

INITIAL VISIT X-RAYS Y / N	**DIAGNOSIS**

TX 1ST VISIT

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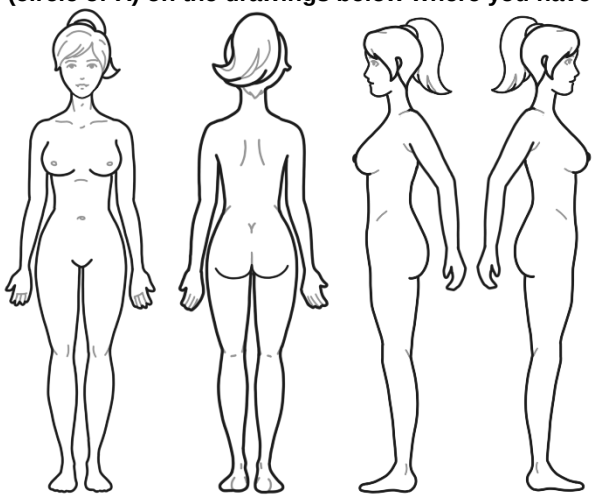
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem caused by: □ Auto Accident □ Worker's Compensation Other_____

2. Indicate (circle or X) on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other: _____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?_____

12. What aggravates your problem? _____

13. What alleviates your problem?(makes it feel better) _____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation _____

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16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription or over-the-counter medications you are currently taking:

_____

21. List all surgical procedures you have had:

_____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today?_____

27. Do you have neck, back or shoulder pain related to breast size? □ No □ Yes

28. Have you used specialized bras or supportive garments for relief? □ No □ Yes

Patient Signature_____ **Date:**_____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff Signature **Date**

Attention Empire, Oxford, Magnacare, BC/BS and GHI Patients,

Please be aware that **YOU** will be receiving payment directly from your insurance carrier.

It is **YOUR RESPONSIBILITY** to provide us with all checks and associated paperwork.

NOTHING WILL BE CHARGED TO YOUR CREDIT CARD UNLESS YOU FAIL TO BRING IN PAYMENTS IN A TIMELY FASHION.

If you fail to bring in payments for services rendered at this office you will be charged for the entire amount.

Thank you for your cooperation.

Name (as it appears on card) _____

Card Number _____

Expiration Date _____

3 Digit CVV/CVC code _____

Billing Address _____

City/State/ZIP _____

Signature _____

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Patient's Pregnancy Evaluation Form

In order for us to fully evaluate you, we are required to take X-rays of some part of your body. It has been found that a fetus (unborn child) in its first trimester would be more sensitive to radiation than an adult. In order to ensure safety, no fetus (unborn child) should be exposed to radiation from X-ray machines, we ask you to provide us with the following information. This information is strictly confidential and solely used for the purpose it is intended. Thank you for your cooperation.

Name: _____

Date of Birth: _____

Date of the onset of Last Menstrual Period: _____

Is there a chance you may be Pregnant? YES / NO (Please circle)

To the best of my knowledge, I am not pregnant and by providing this application form, Physician/Technologist has informed me of the effects of radiation to the unborn baby and me, by signing below have consented to taking the X-ray of my body part, pertinent for evaluation and further studies.

Signature:_____ Date: _____

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Cancellation Policy

(This will be e-mailed to you along with your appointment reminder, the day prior to your appointment)

A fee of **$25** will be charged for any Chiropractic or Physical Therapy session that is cancelled, or rescheduled to a different day, within 24 hours of your appointment time.

Thank you for your consideration.