Morgan Chiropractic, Inc.
New Patient Registration Form

PATIENT INFORMATION

Patient Last Name:			First:	Middle:	Marital Status (circle one) Single/Married/Divorced/Widowed/Other
Date of Birth: ___/___/_____	Age:	Sex: M / F	Social Security Number:	Phone Number:	Email Address:
Address:				City:	State: Zip Code:
Employer:			Job Title:		Employer Phone Number:

INSURANCE INFORMATION (Please have the front desk scan your Insurance card(s))

Is this patient covered by insurance?	Yes / No (if no, please skip this section)		
Primary Insurance Company:			
Secondary Insurance Company:			
AUTO INCIDENT Insurance Name:	Contact Person:	Phone Number:	Claim Number:

SIGNATURE

In exchange for Morgan Chiropractic, Inc.'s forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board, and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgement, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer, or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all my indebtedness, I will remain liable to Morgan Chiropractic, Inc. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Morgan Chiropractic, Inc. are fully paid.

Patient or Guardian Signature:	Date:

CURRENT COMPLAINTS

Nature of Injury: Automobile Accident / Work Incident / Slip and Fall / Other			
Please describe the injury:			
Date of Injury: ___ / ___ / _____	Date Symptoms Appeared: ___ / ___ / _____	Have you ever had this same condition? Yes / No	If yes, when?
List of Practitioners seen for this Injury/condition:			
Have you ever been under chiropractic care?	If yes, briefly describe when and for what injuries/conditions:		

MEDICAL HISTORY

Have you been treated for any conditions in the last year?	Yes / No	If yes, please describe:	
Date of last physical exam (estimate if necessary):		Is there a chance that you are currently pregnant?	Yes / No
Have you had X-rays taken in the last year? Yes / No		If yes, where?	
What medications are you currently taking? (Please include dosage and frequency)			
What vitamins, minerals, supplements, or herbs do you currently take? (Please include dosage and frequency)			

HAVE YOU EVER:	YES	NO	BRIEFLY EXPLAIN:
Broken bones			
Been hospitalized			
Been in an auto accident			
Had sprains/strains			
Been struck unconscious			
Had surgery			
Other medical information you think we should know:			

FAMILY HISTORY		
Has anyone in your family (mother, father, grandparents, siblings, etc.) had any health conditions (Heart disease, Cancer, Diabetes, Arthritis…)		
Please list:		
PAIN AND SYMPTOMS		
Do you experience pain every day?	Yes / No	If yes, explain:
Do your symptoms interfere with daily life?	Yes / No	If yes, explain:
Does pain wake you up at night?	Yes / No	If yes, explain:
Are your symptoms worse during certain times of the day?	Yes / No	If yes, explain:
Do changes in weather affect your symptoms?	Yes / No	If yes, explain:
Do you wear orthotics?	Yes / No	If yes, explain:
What activities aggravate your symptoms?		

HABITS	NONE	LIGHT	MODERATE	HEAVY	OTHER (EXPLAIN)
Alcohol					
Coffee					
Tobacco					
Drugs					
Exercise					
Sleep					
Appetite					
Soft Drinks					
Water					
Salty Foods					
Sugary Foods					

REVIEW OF SYMPTOMS (Circle the following that apply to you)

Have you had any of the following <u>constitutional</u> issues? Chills / Weight Gain / Weight Loss / Fatigue / Daytime Drowsiness / Night Sweats / Fever / Other: _____ / None of the above

Have you had any of the following <u>eye</u> issues? Blindness / Eye Pain / Double Vision / Photophobia / Tearing / Blurred Vision / Field Cuts / Cataracts / Glaucoma / Change in Vision / Itchy Eyes / Wear Contacts or Glasses / Other: _____ / None of the above

Have you had any of the following <u>ENT (Ear Nose Throat)</u> issues? Ear Drainage / Ear Infections / Hearing Loss / Tinnitus / Ear Pain / TMJ / Frequent Nose Bleeds / Loss of Smell / Nasal Congestion / Sinus Infections / Rhinorrhea (runny nose) / Post Nasal Drip / Hoarseness / Difficult Swallowing / Dental Implants / Frequent Sore Throats / Snoring / Discharge / Dizziness / Fainting / Headaches / Other: _____ / None of the above

Have you had any of the following <u>female</u> issues? Birth Control Therapy / Hormone Therapy / Irregular Menstruation / Severe Cramps / Breast Lump or Pain / Abnormal Vaginal Bleeding or Discharge / Burning Urination / Frequent Urination / Urine Retention / Other: _____ / None of the above

Have you had any of the following <u>male</u> issues? Prostate issues / Erectile Dysfunction / Burning Urination / Frequent Urination / Urine Retention / Hestitancy or Dribbling / Other: _____ / None of the above

Have you had any of the following <u>respiratory</u> issues? Asthma / Difficult Breathing / COPD / Emphysema / Other: _____ / None

Have you had any of the following <u>cardiovascular</u> issues? Heart Surgeries / Congestive Heart Failure / Murmurs or Valvular Disease / Heart Attacks or Mis / Heart Disease / Hypertension / Pacemaker / Angina / Irregular Heartbeat / Other: _____ / None

Have you had any of the following <u>gastrointestinal</u> issues? Nausea / Ulcerative Disease / Frequent Abdominal Pain / Hiatal Hernia / Constipation / Bloody or Tacky Stools / Pancreatic Disease / IBS (Irritable Bowel Syndrome) or Colitis / Hepatitis or Liver Disease / Vomiting Blood / Bowel Incontinence / Gastroesophageal Reflux or Heartburn / Other: _____ / None of the above

Have you had any of the following <u>musculoskeletal</u> issues? Rheumatoid Arthritis / Osteoarthritis / Arthitis (unknown type) / Gout / Scoliosis / Spinal Fracture / Spinal Surgery / Joint Surgery / Broken Bones / Metal Implants / Other: _____ / None of the above

Have you had any of the following <u>inegumentary (dermatological)</u> issues? Significant Burns / Significant Rashes / Skin Grafts / Psoriatic Disorders / Other: _____ / None of the above

Have you had any of the following <u>neurological</u> issues? Vision Changes / One Sided Weakness of Face or Body / History of Seizures / Memory Loss / Tremors / Vertigo / Loss of Taste or Smell / Strokes or TIAs / Other: _____ / None of the above

Have you had any of the folloing <u>psychiatric</u> issues? Depression / Suicidal Thoughts / Homocidal Ideations / Schizophrenia / Bipolar Disorder / Psychiatric Diagnosis / Psychiatric Hospitalizations / Other: _____ / None of the above

Have you had any of the following <u>endocrine</u> issues? Thyroid Disease / Diabetes / Hormone Replacement Therapy / Steroid Replacements / Other: _____ / None of the above

Have you had any of the following <u>hematologic/lymphatic</u> issues? Anemia / Regular Anti-inflammatory Use / Abnormal Bleeding or Bruising / HIV Positive / Enlarged Lymph Nodes / Hemophilia / History of Blood Clots / Anticoagulant Therapy / Other: _____ / None

Have you had any of the following <u>allergic an immunological</u> issues? Anaphalaxis / Food Intolerance / Other: _____ / None

Have you had any of the following renal issues? Kidney Stones / Kidney Disease or Damage / Bladder Infections / Hematuria (blood in urine) / Difficulty Urinating / Incontinence / Dialysis / Other: _____ / None of the above

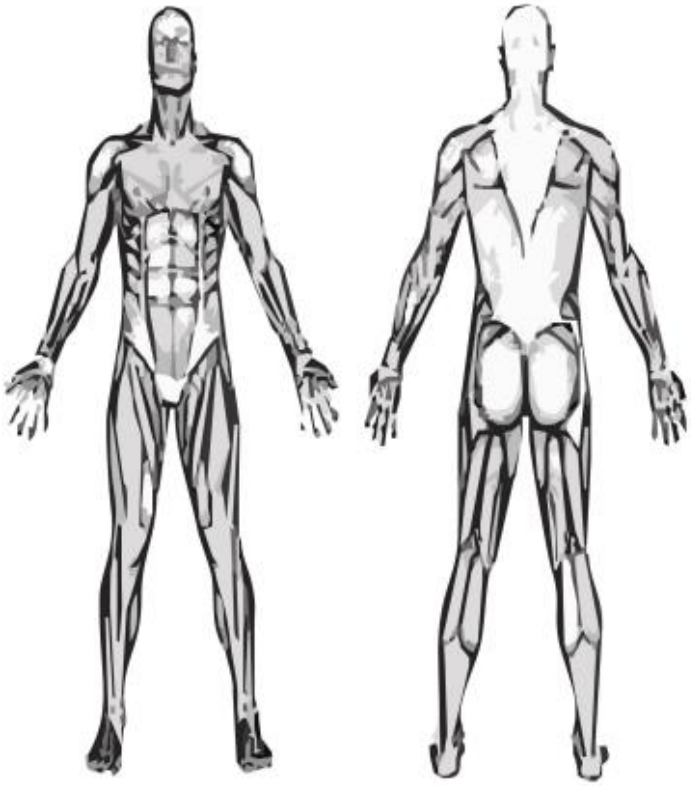
Is there anything else in your medical history that you feel is important to your care here?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Morgan Chiropractic, Inc. to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature:	Date:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

Area of pain: _____

Level of pain (1 being lowest and 10 highest): ___/10

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Signature: _____ *Date* _____

Email Notification Form (Optional)

First Name: _____ Last Name: _____

Email Address: _____

I, _____, agree to allow Morgan Chiropractic, Inc. to send me email notifications of office updates, events, and closures.

We will not give your email address to third parties. If at any time you wish to cancel this subscription, please email our office at morganchiro@gmail.com or call our office at (907) 646-2211 and we will remove you from our email list.

Patient Signature: _____ Date: _____