Morgan Chiropractic, Inc.
New Personal Injury Patient Registration Form

PATIENT INFORMATION					
Patient Last Name:	First Name:	Middle Name:	Marital Status (Select one) Other		
Date of Birth: ___/___/_____	Sex: M / F	SSN:	Phone Number:	Email Address:	
Address:	City:	State:	Zip Code:		
Employer:	Job Title:	Secondary Phone Number:			

INSURANCE INFORMATION		
Patient Car Insurance Company:	Claim #	Adjuster Name and Phone #:
Other Party Insurance Company (if applicable)	Claim #	Adjuster Name and Phone #:
Date of Accident:	Date of Onset of Symptoms:	

AGREEMENT TO PAY ANY BALANCES

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:**

Morgan Chiropractic, Inc.

Patient Name: _____ Date: _____

CURRENT COMPLAINTS			
Please briefly describe the injury:			
Date of Injury: _____ / _____ / _____	Date Symptoms Appeared: _____ / _____ / _____	Have you had this same condition? ___ Yes / ___ No	If yes, please explain:
Practitioners seen for this Injury/condition:			
Have you ever been under chiropractic care? ___ Yes / ___ No	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):	Are currently pregnant? ___ Yes / ___ No	If yes, when are you due?
Have you had X-rays taken in the last year? ___ Yes / ___ No	If yes, where and when?	
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	PLEASE TELL US WHEN AND BRIEFLY DESCRIBE THE EVENT:
Broken any bones	○	○	
Been hospitalized	○	○	
Been in an auto accident	○	○	
Been struck unconscious	○	○	
Had surgery	○	○	

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 or Sugary Foods	○	○	○	○	

Morgan Chiropractic, Inc.

Patient Name: _____ Date: _____

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

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

Have you had any of the following eye 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 ENT (Ear Nose Throat) 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 female 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 male issues? ☐ Prostate issues / ☐ Erectile Dysfunction / ☐ Burning Urination / ☐ Frequent Urination /
☐ Urine Retention / ☐ Hesitancy or Dribbling / Other: _____ / ☐ None of the above

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

Have you had any of the following cardiovascular 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 gastrointestinal 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 musculoskeletal issues? ☐ Rheumatoid Arthritis / ☐ Osteoarthritis / ☐ Arthritis (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 inegumentary (dermatological) issues? ☐ Significant Burns / ☐ Significant Rashes / ☐ Skin Grafts
☐ Psoriatic Disorders / Other: _____ / ☐ None of the above

Have you had any of the following neurological 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 psychiatric issues? ☐ Depression / ☐ Suicidal Thoughts / ☐ Homicidal Ideations / ☐ Schizophrenia
☐ Bipolar Disorder / ☐ Psychiatric Diagnosis / ☐ Psychiatric Hospitalizations / Other: _____ / ☐ None of the above

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

Have you had any of the following hematologic/lymphatic 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 allergic an immunological issues? ☐ Anaphylaxis / ☐ 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:

Phone: (907) 646-2211
Fax: (907) 646-2212
www.morganchiropracticak.com

Morgan Chiropractic, Inc.
11260 Old Seward Hwy Suite 106
Anchorage, AK 99515

Patient Name _____ Date _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ○ a.m. ○ p.m.

Were you the: ○ Driver ○ Front Passenger ○ Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ○ Yes ○ No

Was a police report filed? ○ Yes ○ No

Were there any witnesses? ○ Yes ○ No

Were you wearing a seat belt? ○ Yes ○ No

Was this vehicle equipped with airbags? ○ Yes ○ No

If yes, did it/ they inflate? ○ Yes ○ No

In relation to the base of your skull, where was the headrest? ○ Above ○ Below ○ At base of skull

What did your vehicle impact? ○ Another vehicle ○ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ○ Yes ○ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ○ N ○ S ○ E ○ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the : ○ Front ○ Rear ○ Right Side ○ Left Side ○ Other

During impact, were you facing: ○ Right ○ Left ○ Forward

Were you ○ aware or ○ surprised by the impact?

If accident vehicle made impact with another vehicle…

Direction other vehicle was headed? ○ N ○ S ○ E ○ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

_____

Patient Name _____ Date _____

After Injury

Did accident render you unconscious? ◯ Yes ◯ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ◯ Yes ◯ No

When did you go? ◯ Just after accident ◯ The next day ◯ 2 days plus

How did you get there? ◯ Ambulance ◯ Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ◯ D.C. ◯ M.D ◯ D.O ◯ D.D.S

Describe any treatment you received: _____

Were X-Rays taken? ◯ Yes ◯ No

Was medication prescribed? ◯ Yes ◯ No

Have you been able to work since this injury? ◯ Yes ◯ No

Are your work activities restricted as a result of this injury? ◯ Yes ◯ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/	☐ Lower back pain
☐ Blurred vision	☐ Tension	fingers	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Chest pain	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/ toes
		☐ Stomach upset	

☐ Other _____

_____

Is your condition getting worse? ◯ Yes ◯ No ◯ Constant ◯ Comes and goes

Patient Name _____ Date _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	○	○	○
Lying on side……	○	○	○
Lying on stomach……	○	○	○
Sitting……	○	○	○
Standing……	○	○	○
Stretching……	○	○	○
Lovemaking……	○	○	○
Walking……	○	○	○
Running……	○	○	○
Sports……	○	○	○
Working……	○	○	○
Lifting……	○	○	○
Bending……	○	○	○
Kneeling……	○	○	○
Pulling……	○	○	○
Reaching……	○	○	○

Have you retained an attorney: ○ Yes ○ No

If yes, whom? _____

His/ Her phone #:_____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above
☐ Walking	☐ Crawling	head
☐ Lifting	☐ Bending	☐ Typing
		☐ Stooping

☐ Other _____

Patient Name _____ Date _____

What positions can you work in with minimum physical effort and for how long?

_____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ○ Yes ○ No ○ N/A

Do you work with others who can help you with any heavy lifting? ○ Yes ○ No ○ N/A

While in recovery, is there any light duty work you could request? ○ Yes ○ No ○ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

○ Adult patient ○ Parent or Guardian ○ Spouse

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* _____

Adjusting to a Healthier Life

MCI

Morgan Chiropractic, Inc.

Patient Name:_____ Date: _____

Morgan Chiropractic, Inc.
Medical Records Release

Patient Name: _____ Date of Birth: ____ / _____ / _____

I, the undersigned, authorize Morgan Chiropractic, Inc. to disclose the following information for the patient listed above:

- ◯ All medical records (including but not limited to patient information, medical records, patient ledger, and insurance information)
- ◯ The following medical information: _____

  _____

This information my be disclosed to the following persons/organizations:

Name: _____

Address: _____

Phone Number: _____

I understand that my records are confidential and cannot be disclosed without my written consent, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization my be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include my history, diagnoses, and/or treatment of medical conditions.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Patient or Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____