HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC

Location: 603 7th Street, Unit 301, Laurel, Maryland 20707
Tel: (240) 264 – 6372 Fax: (240) 264 – 6431 Email: info@drtiffanybutler.com

ADULT REGISTRATION FORM

(**Please Print**)

Today's Date: / /	**Patient Account No:**

PATIENT INFORMATION

↓ Last Name:	↓ First Name:	↓ M.I.	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		Home Phone	Cell Phone	Birth date:	Age:	Sex:	
❑ Yes	❑ No	( )	( )	/ /		❑ M	❑ F

Street Address:	P.O. Box:	Social Security #:
		/ /

City:	State:	ZIP Code:	Email Address:

Can we send reminders through text message and/or e-mail?	❑ Yes ❑ No	How did you hear about us? (please check)	❑Internet ❑ Flyer ❑ Friend/Relative ❑
Are you employed?	❑ Yes ❑ No	Student? ❑ Yes ❑ No	
Emergency Contact Name & Number:			

YOUR COMPLAINTS (please mark areas of complaint)

	Muscle and Joint ❑ Headache (e.g. Migraines, Tension) ❑ Neck ❑ Mid-Back ❑ Lower Back ❑Jaw ❑ Shoulder (Right/Left/Both) ❑ Arm (Right/Left/Both) ❑Elbow (Right/Left/Both) ❑ Wrist (Right/Left/Both) ❑ Hip (Right/Left/Both) ❑ Leg (Right/Left/Both) ❑Knee (Right/Left/Both) ❑ Ankle (Right/Left/Both) ❑ Hand (Right/Left/Both) ❑ Foot (Right/Left/Both) ***Other*** ❑ Dizziness ❑ Nausea ❑ Vomiting ❑Difficult Thinking ❑ Confusion ❑ Off-Balance ❑ Un-coordinated ❑ Weakness ❑ Digestive Issues ❑ Poor Posture ❑ Other: _____
How long have you had this condition?	❑ Just started ❑ Few Days ❑ Few Weeks ❑ Months ❑ Years
Is the condition?	❑ Getting better ❑ Getting worse ❑ Stays the same
What seem to be the initial cause of this condition?	
Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s)?	

PAST MEDICAL HISTORY

Review of Systems:

1. Have you had any of the following **pulmonary (lung-related)** issues?
❑ Asthma ❑ Difficulty breathing ❑ Shortness of Breath ❑ COPD ❑ Other: _____ ❑ **None of the above**

2. Have you had any of the following **cardiovascular (heart-related)** issues or problems?
❑ Heart surgery ❑ Congestive Heart Failure ❑ Murmur or valve issues ❑ Heart attack ❑ Heart disease/problems ❑ Hypertension
❑ Angina/chest pain ❑ Irregular heart beat ❑ Take anti-coagulant ❑ Other: _____ ❑ **None of the above**

3. Have you had any of the following **neurological (nerve-relate)** issues?
❑ Visual changes ❑ Vision loss ❑ One-sided weakness (body or face) ❑ History of seizures ❑ One-sided loss of feeling (body or face)
❑ Headaches ❑ Memory loss ❑ Tremors ❑ Loss sense of smell ❑ Difficulty hearing ❑ Loss of hearing ❑ **None of the above**

4. Have you had any of the following **endocrine (glandular/hormonal)** related issues or problems?
❑ Thyroid disease ❑ Hormone replacement therapy ❑ Injectable steroid replacement ❑ Diabetes ❑ **None of the above**

5. Have you had any of the following **renal (kidney-related)** issues or problems?
❑ Renal stones ❑ Hematuria (blood in urine) ❑ Incontinence (can't urinate) ❑ Bladder infections ❑ Difficulty urinating ❑ Kidney disease
❑ Dialysis ❑ Other: _____ ❑ **None of the above**

6. Have you had any of the following **gastroenterological (stomach-related)** issues?
❑ Nausea ❑ Difficulty swallowing ❑ Ulcerative disease ❑ Frequent abdominal pain ❑ Hiatal hernia ❑ Constipation ❑ Pancreatic disease ❑ Irritable bowel/colitis ❑ Hepatitis or liver disease ❑ Blood or black stools ❑ Vomiting blood ❑ Bowel incontinent
❑ GERD/acid reflux ❑ Other: _____ ❑ **None of the above**

7. Have you had any of the following **hematological (blood-related)** issues?
❑ Anemia ❑ Auto Immune Disease ❑ Abnormal bleeding/bruising ❑ Sickle-Cell Anemia ❑ Enlarged lymph nodes ❑ Hemophilia
❑Deep vein thrombosis ❑ Blood clots ❑ Anticoagulant therapy ❑ Regular use of Aspirin ❑ Other: _____ ❑ **None of the above**

8. Have you had any of the following **dermatological (skin-related)** issues?
❑ Significant burns ❑ Significant rashes ❑Skin grafts ❑ Psoriasis ❑ Eczema ❑ Other: _____ ❑ **None of the above**

9. Have you had any of the following **musculoskeletal (muscle/bone-related)** issues?
❑ Rheumatoid arthritis ❑ Gout ❑ Osteoarthritis ❑ Brittle bones ❑ Spinal fracture ❑ Spinal surgery ❑ Arthritis ❑ Scoliosis
❑ Metal implants ❑ Osteoporosis ❑ Other: _____ ❑ **None of the above**

10. Have you had any of the following **psychological** issues?
❑ Psychiatric diagnosis ❑ Depression ❑ Bi-polar disorder ❑ Schizophrenia ❑ PTSD ❑ Other: ❑ **None of the above**

Please list previous Injury or Trauma: (if none, market ❑ **None)**

Have you ever broken any bones? ❑ Yes ❑ No

Any allergies? ❑ Yes ❑ None

Please list any medications you currently take:
Medication Name: _____ Reason for taking: _____
Medication Name: _____ Reason for taking: _____
Medication Name: _____ Reason for taking: _____
Medication Name: _____ Reason for taking: _____

Please list any surgeries you've had:
Date: _____ Type of Surgery: _____
Date: _____ Type of Surgery: _____

For WOMEN: When was your last period?	
For WOMEN: Are you currently pregnant?	❑ Yes ❑ No
Are you seeing any other doctor now for any reason? If ***yes,*** Name of Doctor:	❑ Yes ❑ No
Have you been hospitalized in the last 5 years?	❑ Yes ❑ No

LIFESTYLE

Do you take minerals, herbs, vitamins or supplements? If ***yes,*** please indicate.	❑ Yes ❑ No
How would you rate your health?	❑ Poor ❑ Fair ❑ Good ❑ Excellent

SOCIAL AND OCCUPATIONAL HISTORY

Do you drink alcohol?	❑ Yes ❑ No
Do you use tobacco?	❑ Yes ❑ No
Do you use recreational drugs?	❑ Yes ❑ No
Do you exercise?	❑ Yes ❑ No
How many hours of sleep to do you get?	❑ 4-6 hours/ night ❑ 6+ hours/night
What's your occupations/job description?	
What is your work schedule?	❑ Full-time ❑ Part-time ❑ Night shift ❑ Day Shift
What activities do you do at work?	❑ Lifting ❑ Bending ❑ Stooping ❑ Kneeling ❑ Twisting ❑ Sitting ❑ Walking ❑ Standing ❑ Driving ❑ Pushing ❑ Pulling ❑ Carrying

FAMILY HISTORY (IF ANY BLOOD RELATIVES HAVE CONDITION, PLEASE MARK)

❑ Asthma ❑ Emphysema ❑ High Blood Pressure ❑ Diabetes ❑ Stomach Problems ❑ Thyroid Disease ❑ High Cholesterol
❑ Heart Attack ❑ Stroke ❑ Arthritis-Rheumatism ❑ Circulation Problems ❑ Osteoporosis ❑ Kidney Disease
❑ Mental Disorder ❑ Cancer ❑ Other: _____

Do you have any other health issues or concerns that our staff should be aware of? ❑ **YES** ❑ **NO**

ACCEPTANCE AS A PATIENT

Have you ever received chiropractic care before?	❑ Yes ❑ No

I understand and agree that the doctors of **HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept me as a patient.

Patient Signature _____ ***Date*** _____

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INSURANCE & FINANCIAL AGREEMENT

Last Name:	First Name:	Middle Initial:

PRIMARY INSURANCE INFORMATION	
Name:	Policy Number:
Group No:	Claim Number:
Claims Mailing Address:	City:
State:	ZIP:
Phone No:	Fax No:
SECONDARY INSURANCE INFORMATION	
Name:	Policy Number:
Group No:	Claim Number:
Claims Mailing Address:	City:
State:	ZIP:
Phone No:	Fax No:

FINANCIAL AGREEMENT

Would you like for us to bill your insurance company on my behalf? ❑ Yes ❑ No

- I hereby authorize this office to release any medication information request to my insurance company to process my claim for benefits.
- I authorize the payment of medical benefits to the chiropractor provider for services rendered to me.
- **I understand that I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT of all charges and fees**.
- **I understand that the amount that my insurance company reimburses to the chiropractor may not satisfy the full payment in this case, I AM RESPONSIBLE FOR PAYING THE DIFFERENCE (the balance).**

Patient Signature _____ ***Date*** _____

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MISSED APPOINTMENT POLICY

Purpose
To make the patient aware that missed appointments have an impact on the physician's schedule as well as possible health risks for the patient.

Policy
To notify patients of a possible financial penalty for failure to cancel a scheduled appointment. Our office will document in the electronic medical record when a patient no shows an appointment or cancels an appointment on short notice. Failure to give 24 hour notice of cancellation of an appointment or no-showing an appointment can result in a charge of $25.00 on the patient's account.
Patients are advised of this when scheduling their appointment. This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts.
No showing for three (3) scheduled appointments may result in the patient being discharged from the practice, at the physician's discretion.

Procedure

Check **ONE** Box. **Sign and Date** Below

[ ] **YES. I understand the Missed Appointment Policy.** I have been informed that a $25 charge will be applied to my account when I miss appointments without giving proper notice. I understand that this charge cannot be billed to an insurance company. I agree to be personally and fully responsible for payment.
[ ] **NO. I have decided not to receive services at this office.**

_____ _____
Signature of Patient/Guardian Date