File #\_\_\_\_\_\_\_\_\_\_\_\_\_

JOHNSON CHIROPRACTIC HEALTH & WELLNESS

REGISTRATION & HISTORY

**INSURANCE INFORMATION**

Who is responsible for this account?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_

Additional or Secondary Insurance? Yes\_\_\_\_\_ No\_\_\_\_\_

Secondary Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and assign directly to Todd D. Johnson D.C., F.A.S.F.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. Dr. Johnson D.C., F.A.S.F.A., may use my health care information and may disclose such information to Dr. Johnson’s Insurance Company(ies) and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Print Name of Patient/Parent/Guardian/Personal Representative Signature

**ACCIDENT INFORMATION**

Is condition due to an accident? Yes\_\_\_\_\_ No\_\_\_\_\_ Date\_\_\_\_\_ Type of accident-Auto\_\_\_\_\_ Work\_\_\_\_\_ Home\_\_\_\_\_ Other\_\_\_\_

To whom have you made a report of your accident?\_\_\_\_\_\_\_\_\_\_\_ Auto Insurance-Employer\_\_\_\_ Worker\_\_\_\_ Comp\_\_\_\_ Other\_\_\_

Attorney Name (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

PLEASE PRINT Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Patient Under 18? Y\_\_\_\_\_ N\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Residential Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE NUMBERS**

Cell Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

Best time and place to reach you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex M\_\_\_\_\_ F\_\_\_\_\_ Age\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_

Married\_\_\_\_\_ Widowed\_\_\_\_\_ Single\_\_\_\_\_ Minor\_\_\_\_\_ Separated\_\_\_\_\_ Divorced\_\_\_\_\_ Partnered for\_\_\_\_\_years

Patient Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext\_\_\_\_\_

How Did You Hear About Us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PATIENT REASON FOR VISIT**

Reason for Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms appear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting progressively worse? Yes\_\_\_\_\_ No\_\_\_\_\_\_ Unknown\_\_\_\_\_

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_\_\_

Type of pain:

Sharp\_\_\_ Dull\_\_\_ Throbbing\_\_\_ Numbness\_\_\_ Aching\_\_\_ Shooting\_\_\_

Burning\_\_\_ Tingling\_\_\_ Cramps\_\_\_ Stiffness\_\_\_ Swelling\_\_\_ Other\_\_\_

How often do you have this pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it constant or does it come and go?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with:

Work\_\_\_\_\_ Sleep\_\_\_\_\_ Daily Routine\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities or movements that are painful to perform:

Sitting\_\_\_\_\_ Standing\_\_\_\_\_ Walking\_\_\_\_\_ Bending\_\_\_\_\_ Lying Down\_\_\_\_\_

*Mark and X* on the picture where you continue to have pain, numbness, or tingling.

**HEALTH HISTORY**

What treatment have you already received for you condition?

Medications\_\_\_\_\_\_ Surgery\_\_\_\_\_\_ Physical Therapy\_\_\_\_\_\_ Chiropractic Services\_\_\_\_\_\_ None\_\_\_\_\_\_ Other\_\_\_\_\_\_

Who has treated you for your condition:

Doctor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Doctor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Date of Last:

Physical Exam\_\_\_\_\_\_\_\_ Spinal X-Ray\_\_\_\_\_\_\_\_ Blood Test\_\_\_\_\_\_\_\_ Spinal Exam\_\_\_\_\_\_\_\_

Chest X-Ray\_\_\_\_\_\_\_\_ Urine Test\_\_\_\_\_\_\_\_ Dental X-Ray\_\_\_\_\_\_\_\_ MRI/CT-Scan\_\_\_\_\_\_\_\_ Bone Scan\_\_\_\_\_\_\_\_

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

Yes\_\_\_ No\_\_\_ AIDS/HIV Yes\_\_\_ No\_\_\_ Chicken Pox Yes\_\_\_ No\_\_\_ Liver Disease

Yes\_\_\_ No\_\_\_ Rheumatoid Arthritis Yes\_\_\_ No\_\_\_ Alcoholism Yes\_\_\_ No\_\_\_ Diabetes

Yes\_\_\_ No\_\_\_ Measles Yes\_\_\_ No\_\_\_ Rheumatic Fever Yes\_\_\_ No\_\_\_ Allergy Shots

Yes\_\_\_ No\_\_\_ Emphysema Yes\_\_\_ No\_\_\_ Migraine Headaches Yes\_\_\_ No\_\_\_ Scarlet Fever

Yes\_\_\_ No\_\_\_ Anemia Yes\_\_\_ No\_\_\_ Epilepsy Yes\_\_\_ No\_\_\_ Miscarriage

Yes\_\_\_ No\_\_\_ Stroke Yes\_\_\_ No\_\_\_ Anorexia Yes\_\_\_ No\_\_\_ Fractures

Yes\_\_\_ No\_\_\_ Mononucleosis Yes\_\_\_ No\_\_\_ Suicide Attempt Yes\_\_\_ No\_\_\_ Appendicitis

Yes\_\_\_ No\_\_\_ Glaucoma Yes\_\_\_ No\_\_\_ Multiple Sclerosis Yes\_\_\_ No\_\_\_ Thyroid Problems

Yes\_\_\_ No\_\_\_ Arthritis Yes\_\_\_ No\_\_\_ Goiter Yes\_\_\_ No\_\_\_ Mumps

Yes\_\_\_ No\_\_\_ Tonsillitis Yes\_\_\_ No\_\_\_ Asthma Yes\_\_\_ No\_\_\_ Gonorrhea

Yes\_\_\_ No\_\_\_ Osteoporosis Yes\_\_\_ No\_\_\_ Tuberculosis Yes\_\_\_ No\_\_\_ Bleeding Disorders

Yes\_\_\_ No\_\_\_ Gout Yes\_\_\_ No\_\_\_ Pacemaker Yes\_\_\_ No\_\_\_ Tumors/Growths

Yes\_\_\_ No\_\_\_ Breast Lump Yes\_\_\_ No\_\_\_ Heart Disease Yes\_\_\_ No\_\_\_ Parkinson’s Disease

Yes\_\_\_ No\_\_\_ Typhoid Fever Yes\_\_\_ No\_\_\_ Bronchitis Yes\_\_\_ No\_\_\_ Hepatitis

Yes\_\_\_ No\_\_\_ Pinched Nerve Yes\_\_\_ No\_\_\_ Ulcers Yes\_\_\_ No\_\_\_ Bulimia

Yes\_\_\_ No\_\_\_ Hernia Yes\_\_\_ No\_\_\_ Pneumonia Yes\_\_\_ No\_\_\_ Vaginal Infections

Yes\_\_\_ No\_\_\_ Caner Yes\_\_\_ No\_\_\_ Herniated Disk Yes\_\_\_ No\_\_\_ Polio

Yes\_\_\_ No\_\_\_ Venereal Disease Yes\_\_\_ No\_\_\_ Cataracts Yes\_\_\_ No\_\_\_ Herpes

Yes\_\_\_ No\_\_\_ Prostate Problem Yes\_\_\_ No\_\_\_ Whooping Cough Yes\_\_\_ No\_\_\_ Chemical Dependency

Yes\_\_\_ No\_\_\_ High Cholesterol Yes\_\_\_ No\_\_\_ Prosthesis Yes\_\_\_ No\_\_\_ Kidney Disease

Yes\_\_\_ No\_\_\_ Psychiatric Care Yes\_\_\_ No\_\_\_ Other

**MEDICATIONS**

Name of Medication Dosage Amount Prescribing Doctor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**VITAMINS / HERBS / MINERALS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INJURIES/SURGERIES DESCRIPTION** **DATE**

Falls:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injuries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dislocations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT ARE YOU DOING FOR YOUR INJURIES:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WHAT HAS WORKED BEST FOR YOU:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes\_\_\_\_\_ No\_\_\_\_\_ Due Date\_\_\_\_\_\_\_\_\_\_

**PATIENT CONDITION**

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

**EXERCISE WORK ACTIVITY HABITS**

\_\_\_\_\_ None \_\_\_\_\_Sitting \_\_\_\_\_Smoking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Packs/Day

\_\_\_\_\_ Moderate \_\_\_\_\_Standing \_\_\_\_\_Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drinks/Weeks

\_\_\_\_\_ Daily \_\_\_\_\_Light Labor \_\_\_\_\_Coffee/Caffeine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drinks Cups/Day

\_\_\_\_\_ Heavy \_\_\_\_\_Heavy Labor \_\_\_\_\_High Stress Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason

**TREATMENTS/SERVICES/PRODUCTS INTERESTED IN OR WOULD LIKE TO FIND OUT MORE ABOUT:**

\_\_\_\_\_ Chiropractic \_\_\_\_\_ Consultation for Treatment Options

\_\_\_\_\_ Medical Wave Pressure Therapy \_\_\_\_\_Sports Physicals

\_\_\_\_\_ Ultrasound Therapy \_\_\_\_\_Stretching / Strengthening Exercises

\_\_\_\_\_ Electrical Muscle Stimulation Therapy \_\_\_\_\_Heat / Cold Therapy

\_\_\_\_\_ Acupuncture \_\_\_\_\_Physiotherapy

\_\_\_\_\_ Postual ReEducation \_\_\_\_\_Itersegmental Traction Therapy

\_\_\_\_\_ Massage Therapy \_\_\_\_\_ Reflexology / Soft Tissue Trigger Point Release

\_\_\_\_\_ Chronic Pain Education \_\_\_\_\_ CBD Oil

\_\_\_\_\_ Nutrition Supplements \_\_\_\_\_ Health and Wellness Aids and Products

\_\_\_\_\_ Diet / Nutrition Counseling \_\_\_\_\_ Diabetic Education

NOTES:

TODD D. JOHNSON D.C., F.A.S.F.A.

CONFIDENTIAL PATIENT INFORMATION

**CONSENT FOR EXAMINATION, X-RAYS, AND CHIROPRACTIC SERVICE**

I consent to have a complete examination performed to determine if my condition may be considered for chiropractic care.

I agree to bring any x-rays films, ordered elsewhere for this clinic shall become a part of this clinic’s professional records and shall be subject solely to the control and disposition of the doctor.

I also give consent to Dr. Todd Johnson D.C., F.A.S.F.A., to administer whatever treatment or therapeutic procedures or devices as deemed necessary to treat my condition.

The doctor will go over my examination and/or x-ray results during the follow-up appointment to answer any questions I may have.

I acknowledge that no guarantee or assurance of the results of treatment can be given to me by the above attending chiropractor, associate or assistants.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN COMPLETE ONLY IF TREATMENT FOR A MINOR CHILD**

I hereby authorize the doctor of Johnson Chiropractic Health Center to administer procedures, as outlined above, for my son/daughter/other.

Name of Child: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOHNSON CHIROPRACTIC HEATLTH AND WELLNESS

FINNCIAL RESPONSIBILITY

**Johnson Chiropractic Health and Wellness accepts Cash, Personal Checks, Visa, Mastercard and Discover as payments for services. Please remember, it is the patients responsibility to know what their insurance benefits are and if a referral is needed to see our provider. If you have any concerns regarding your insurance coverage, please call the number on the back of your card for a full explanation of your coverage. Our financial policy is as follows:**

* **Insurance Co-Payments**: Must be paid at the time services are rendered.
* **Deductibles/Co-Insurance:** If your deductible has not been met full payment of the services rendered will be required at the time of service along with any applicable co-insurance amounts until your deductible has been met.
* **Private Pay/Non-Contracted Insurance Companies:** If you do not have insurance coverage or have coverage with an insurance we are not contracted with, you will be responsible for making payment in full or making payment arrangements.
* **Collection Policy:** If your account is placed with a collection agency, all future visits would require payment in full at the time of service. You will be held fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of this debt. These fees are over and above the original balance due.
* **Returned Checks:** A $35.00 fee will be added to your account for any returned checks.
* **No Show Appointments:** There will be a $25.00 fee charged to any account for no show appointments.

**It is very important to stay informed about your insurance coverage. If you have a new insurance, it is your responsibility to provide an updated card. You will be responsible for the total amount of any unpaid claims that are denied for incorrect insurance information.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

PRIVACY NOTICE

**THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW.**

**YOUR CONFIDENTAL HEALTHCARE INFORMATION**

* May be released to other healthcare professionals within the facility for providing you with quality healthcare.
* May be released to your insurance provider for receiving payment for healthcare services.
* May be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
* May be released to other healthcare providers in the event you need emergency care.
* May be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication)
* May not be released for any other purpose that which is identified in this notice.
* Johnson Chiropractic Health and Wellness is required by law to protect the privacy of its patients. We will keep confidential all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information. We will abide by the terms of this notice. We reserve the right to make changes to this notice.
* You have the right to complain to Johnson Chiropractic Health and Wellness if you believe your rights to privacy have been violated. All complaints should be mailed to Johnson Chiropractic Health and Wellness. All complaints will be investigated. No personal issue will be raised for filing a complaint.

**For Further information about this Privacy Notice please contact:** Johnson Chiropractic Health and Wellness

I AUTHORIZE \_\_\_\_\_\_\_\_\_\_ I DO NOT AUTHORIZE\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed:\_\_\_\_\_\_\_