PATIENT REGISTRATION (PLEASE PRINT)

NAME(last) _____(first)_____(MI.)____

DATE OF BIRTH_____ AGE_____ SEX____ MARITAL STATUS_____

SS#:_____ DRIVER'S LICENSE #:_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____WORK PHONE_____

CELL PHONE_____ Email_____

OCCUPATION_____YEARS_____

EMPLOYER_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PREVIOUS OCCUPATIONS AND APPROX YEARS AT EACH_____

_____

WHO REFERRED YOU TO THIS OFFICE?_____

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN AN EMERGENCY

_____

DOCTOR LAST CONSULTED_____DATE_____

ADDRESS_____CITY_____ST____ZIP_____

REASON_____

PRIOR CHIROPRACTIC TREATMENT (doctor's name, date, reason)

_____

INSURANCE INFORMATION (Check type , provide name and ID#)

☐HEALTH ☐AUTO ☐MEDICARE

_____

REASON FOR THIS VISIT_____

WORK INJURY? Yes No AUTOMOBILE ACCIDENT? Yes No

DATE OF ONSET_____ HAVE YOU MISSED WORK?___DAYS___WKS___MOS

>>> P L E A S E C O M P L E T E R E V E R S E <<<

Richard A. Collins, D.C.3131 Foothill Blvd., Ste. E, La Crescenta, CA 91214 (818)957-6040

CONFIDENTIAL PATIENT HISTORY

LIST ANY OTHER PERSISTENT OR RECURRENT COMPLAINTS:

_____

_____

PREVIOUS ACCIDENTS/INJURIES (Please list and give approx dates)

_____

_____

SURGERIES (Please list, give approx dates and any complications)

_____

_____

ARE YOU ON ANY MEDICATIONS OR SPECIAL DIET? (Please list)

_____

ANY HISTORY OF.... (list family member)	DO YOU USE.....
☐ Cancer ----------: _____	Coffee?_____cups/day
☐ Diabetes ----------: _____	Tea?_____cups/day
☐ Heart disease --------: _____	Tobacco?____packs/day
☐ Stroke ----------: _____	Alcohol?_____
☐ High Blood Pressure --: _____	Drugs?_____
☐ Lung Disease ---------: _____	
☐ Kidney Disease -------: _____	LIFE-SAVING devices?
☐ Mental Disorders -----: _____	_____
☐ Bone Disorders -------: _____	
☐ Contagious Disorders--: _____	
☐ Allergies ----------: _____	

MARITAL HISTORY:	WOMEN ONLY:
Years Married_____	Are you now pregnant?___ Due Date:_____
Spouses Name :	Date of last menstrual period_____
_____	Length of normal menstrual period_____
# of Children_____	Length of normal menstrual cycle_____
Ages_____	****SIGNATURE TO VERIFY NON-PREGNANCY :**

SIGN HERE (If applicable)

DAILY ROUTINE	
Do you normally:	Number of work hours per day? _____
☐ Eat Breakfast?	Approximate number of hours you...
☐ Eat Lunch?	Sit_____ Stand_____ Walk_____
☐ Eat Dinner?	
☐ Exercise?	Usual number of hours of sleep_____
(list type/amount below)	Normal sleep position_____

_____

SIGNATURE VERIFIES AUTHORIZATION FOR EXAMINATION/TREATMENT, ACKNOWLEDGEMENT OF OFFICE PRIVACY POLICIES AND CONFIRMS FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED REGARDLESS OF ANY ASSUMED INSURANCE COVERAGE OR THIRD PARTY LIABILITY.

Date_____ Signature _____ SIGN HERE

(If patient is under 18, parent must sign for authorization)

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Richard A. Collins, DC
Chiropractor / Qualified Medical Examiner

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Patient Privacy Notification, Informed Consent & Authorization

You have certain rights regarding the privacy of your medical records. Federal law mandates that we advise you of these rights. You have the right to refuse authorization for Dr. Collins' office to furnish any information to *any* entity, at any time if you choose so, without any threat of repercussion. Such refusal, in the case of insurance claims, may cause delay or denial of claims. You are ultimately responsible, in either case, for payment of any and all services provided by this office. My signature below attests that I have read or chosen not to read the posted office policy regarding HIPAA compliance and/or, if requested, have received a copy of same.

When applicable, we use the statement, "Signature on File" on insurance forms which we process on your behalf, and need written authorization on file to do so. Your authorization will allow us to continue to file insurance forms, both paper and electronically as needed without having to get your signature on every claim.

Dr Collins uses hands-on, manual manipulation techniques along with various adjunctive therapies. As with most health care treatments, there is inherent risk with regards to chiropractic adjustments and these related procedures, including but not limited to temporary increased pain, skin reactions from therapy application and the rare occurrence of fracture or stroke (with neck manipulation) from underlying disorders; my signature below acknowledges being informed of these risks and gives my consent to Dr. Collins' office to perform said treatments, as well as acknowledges the other rights and statements herein contained and, if applicable, authorizes release of information to my insurance company (or other directly involved entity) regarding my care at this office; if not previously paid by the patient, this also authorizes direct payment for services to Dr. Collins with regards to claims processing.

This attestation and agreement serve as a facsimile regarding all relevant stated issues and insurance claims processed by this office on my behalf. Authorization to release information to any *other* entity must be obtained from me in writing.

_____
Printed Name

_____ (Please note, if other than English, may require the presence
Preferred Language of an interpreter or referral to an appropriate facility)

Signature _____ Date_____