☐ 5471 Kearny Villa Rd Ste 200 San Diego, CA 92024
Tel (858) 571-0606 Fax: (858) 571-1933
☐ 499 N. El Camino Real Ste C-200 Encinitas, CA 92024
Tel. (760) 635-7800 Fax: (760) 635-7801

Date:

Account #:_____ MD#: _____

PATIENT REGISTRATION FORM (☐ New ☐ Update)

Your email: _____ **Your Pharmacy:** _____
(Name/Telephone Number)

PLEASE FILL OUT COMPLETELY. FAILURE TO DO SO MAY DELAY PAYMENT OF YOUR CLAIM. INDICATE N/A IF NOT APPLICABLE.

HAVE YOU EVER BEEN SEEN IN THE OFFICE BEFORE ☐ yes ☐ no if yes: Date: _____ Dr. _____

PATIENT'S FULL NAME _____ SEX M ___ F ___ Home # _____ Cell # _____

ADDRESS _____
Street City State Zip

BIRTHDATE _____ AGE_____ DRIVER'S LICENSE # _____ MARITAL STATUS _____

S.S. #_____ DATE OF INJURY _____ JOB ( ) AUTO ( ) OTHER ( )

EMPLOYER _____ OCCUPATION _____ Work Phone #_____

EMPLOYER ADDRESS _____
Street City State Zip

Race_____ **Ethnicity**_____ **Language:** _____

RESPONSIBLE PARTY Name_____ Home Phone# _____ Work Phone # _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐ Other_____

Address _____
Street City State Zip

Employer _____ Work Phone # _____

EMERGENCY CONTACT Name_____ Home Phone #_____ Work Phone #_____

Referred by (check one) ☐ Family ☐ Friend ☐ Insurance ☐ **Physician** _____ ☐ Other _____
Name/Telephone Number

PRIMARY INSURANCE. ☐ CASH ☐ MEDICARE ☐ MEDI-CAL ☐ PPO ☐ HMO ☐ WORKCOMP ☐ IME/AME ☐ AUTO

CARRIER _____

CO-PAY _____ I.D. #_____ Group # _____

Insurance Address _____ Phone # _____
Street City State Zip

Policy Holder S.S. # of Insured _____

Insured's Address _____
Street City State Zip

Employer of Insured _____ Work Phone #_____

SECONDARY INSURANCE

CARRIER _____

CO-PAY _____ I.D. #_____ Group # _____

Insurance Address _____ Phone # _____
Street City State Zip

Policy Holder S.S. # of Insured _____

Insured's Address _____

Employer of Insured_____ Work Phone #

I hereby assign all benefits directly to OASIS MD Providers and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices.

I understand that even if a patient carries medical insurance, professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to. I accept financial responsibility for all charges incurred and hereby promise to pay all charges promptly, including those not paid by my insurance. If my account has to be referred to outside collection I will be charged a service charge to cover the additional collection costs.

I also authorize OASIS MD to request and review my medications history from my pharmacy to facilitate pharmacy orders and refills.

I certify that all of the information provided herein is true and correct.

X _____ _____
Signature of Patient (or legal guardian if patient is a minor) Date

Travis C. Ehlers, DC, CCSP

Informed Consent To Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays, physical therapy or any procedures used by Dr. Ehlers or staff in this office on me, (or on the patient named below for which I am legally responsible) which are recommended by Dr. Ehlers or staff at Oasis MD Lifestyle Healthcare.

I understand that, as with all health care procedures, there are certain complications which may arise during an adjustment. Those complications include, but are not limited to: factures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation to the neck have been associated with injuries to the arteries of the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all the risks and complications and I wish to rely on the doctor to exercise his or her judgment during the course of the procedures which the doctor feels at the time, based upon the facts then know, are in my best interest.

I understand that my doctor will be unable to perform any services without my acknowledgement of the above and without my consent as indicated by signing this form. If I have any questions about the above or the information in this form, I will address these with the doctor prior to initial treatment.

I have read or have had read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient/Guardian/Representative Date

8901 Activity Road, San Diego, CA 92126
Tel. (844) 627-4763 Fax: (760) 635-7801
499 N. El Camino Real Ste C-200 Encinitas, CA 92024
Tel. (760) 635-7800 Fax: (760) 635-7801

Patient Name: _____ DOB: _____ Account #: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In accordance with the Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPAA), I, _____, hereby authorize *OASIS MD* to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time.

I also authorize *OASIS MD* to discuss my condition, treatment or diagnosis to the following family members, individuals and/or caregivers:

_____ _____
(Name) Relationship

_____ _____
(Name) Relationship

Home Phone: _____ May we leave a detailed message: YES/NO
Cell Phone: _____ May we leave a detailed message: YES/NO
E-Mail: _____ May we send you a detailed message: YES/NO

_____ _____
PATIENT SIGNATURE DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

I, _____, understand that under the Healthcare Portability Act of 1996 (*HIPAA*) I have certain rights to privacy regarding my Protected Health Information (*PHI*). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from Third-Party Payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my *PHI*. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing how my *PHI* is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
PATIENT SIGNATURE DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature to confirm receipt of the Notice of Privacy Practices but was unable to do so as documented below:

Date:	Initials:	Reason:

OasisMD
Lifestyle Healthcare

Patient Name:_____ **DOB:** _____ **Patient ID#:**_____

Patient Financial Liability Statement

I, the patient or legal representative for the patient, understand that I am personally financially responsible for charges incurred for services rendered by Oasis MD, if any of the following apply:

1) My health plan required prior authorization or referral by my Primary Care physician forbore receiving services at Oasis MD and I have not obtained the authorization or referral as needed to comply with insurance plan policy or I have received services more than what was approved; **and/or**

2) My health plan determines that the services rendered at the Oasis MD are not medically necessary or are not a covered benefit under my health plan policy; **and/or**

3) My health plan coverage has lapsed or expired at the time I received services at Oasis MD; **and/or**

4) Oasis MD is not a contracted provider for my health plan and I have agreed to pay CASH and/or higher copays/deductible/co-insurance for all services rendered.

I also understand that I am responsible for all deductibles, co-payments and co-insurance under my Health Plan.

If my account must be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

I am the patient or am authorized to sign this agreement. I have received a copy, and understand and accept its terms.

_____ _____

Patient /Legal Representative Signature **Relationship**

_____ _____

Witness **Date**

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No Affected Sleep: ◯Yes ◯No

Missed Work: ◯Yes ◯No Unable to Work from: _____ Unable to Work til: _____

Affected Appetite: ◯Yes ◯No Explain: _____

Reduced Work: ◯Yes ◯No Explain: _____

Does it Worsen: ◯Yes ◯No Explain: _____

Weather Affects it: ◯Yes ◯No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯Yes ◯No Explain: _____

X-rays Taken: ◯Yes ◯No Explain: _____

Same Condition Before: ◯Yes ◯No Date: _____ Practitioner: _____

History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Surgeries/Hosp: _____

Previous Chiro Care: ◯Yes ◯No Date: _____ Explain: _____

Chance Pregnant: ◯Yes ◯No Planning: ◯Yes ◯No

Medications: _____

Supplements: _____

Broken Bones: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Sprains/Strains: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Hospitalized: ◯Yes ◯No Explain: _____

Surgery: ◯Yes ◯No Explain: _____

Auto Accident: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Struck Unconscious: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Eating Disorder: ◯Yes ◯No Explain: _____

Stroke: ◯Yes ◯No Explain: _____

Family Health Hist: _____

Health Checklist

- [ ] Allergies
- [ ] Arteriosclerosis
- [ ] Back Pain
- [ ] Bruise Easily
- [ ] Cold Extremities
- [ ] Depression
- [ ] Dizziness
- [ ] Fatigue
- [ ] Hemorrhoids
- [ ] Irregular Heart Beat
- [ ] Kidney Stones
- [ ] Loss of Smell
- [ ] Pacemaker
- [ ] Prostate Trouble
- [ ] Spinal Curvatures
- [ ] Swollen Joints
- [ ] Ulcers
- [ ] Alcoholism
- [ ] Arthritis
- [ ] Breast Lump
- [ ] Cancer
- [ ] Constipation
- [ ] Diabetes
- [ ] Excessive Menstruation
- [ ] Frequent Urination
- [ ] High Blood Pressure
- [ ] Irregular Menstrual Cycle
- [ ] Loss of Memory
- [ ] Loss of Taste
- [ ] Polio
- [ ] Sciatica
- [ ] Sinus Infection
- [ ] Stroke
- [ ] Thyroid Condition
- [ ] Varicose Veins
- [ ] Anemia
- [ ] Asthma
- [ ] Bronchitis
- [ ] Chest Pain
- [ ] Cramps
- [ ] Digestion Problems
- [ ] Eye Pain or Difficulties
- [ ] Headache
- [ ] Hot Flashes
- [ ] Kidney Infection
- [ ] Loss of Balance
- [ ] Nosebleeds
- [ ] Poor Posture
- [ ] Shortness of Breath
- [ ] Insomnia
- [ ] Swelling of Ankles
- [ ] Tuberculosis
- [ ] Venereal Disease

- [ ] Other: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included informatio and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of th above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself.

Patient Signature: _____ Date: _____