ADVANCED BACK & NECK PAIN CENTER
PATIENT REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

How did you hear about us: _____

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. Richard McKay & Dr. Travis McKay all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** yes ____ no ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Medications: *(please list all medications and supplements that you currently take)*

Allergies: *(please list all medications that cause allergic reaction)*

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ pulmonary embolism
- ☐ pneumonia
- ☐ tuberculosis
- ☐ respiratory arrest
- ☐ sleep apnea
- ☐ other: _____

Cardiac / Heart and peripheral vascular disease

- ☐ chest pain / angina
- ☐ heart attack, myocardial infarction
- ☐ congestive heart failure
- ☐ other: _____
- ☐ high blood pressure
- ☐ heart murmur, valve disorder
- ☐ mitral valve prolapse
- ☐ bleeding problems
- ☐ irregular heartbeat, arrhythmia
- ☐ peripheral vascular disease
- ☐ deep vein thrombosis

Neurologic Disorders

- ☐ stroke or TIA
- ☐ peripheral neuropathy
- ☐ other: _____
- ☐ parkinson's
- ☐ MS
- ☐ cerebral palsy
- ☐ polio

Bone & Joint Disorders

- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other: _____
- ☐ gout
- ☐ lupus
- ☐ osteomyelitis
- ☐ ankylosing spondylitis

Gastrointestinal Disorders

- ☐ peptic ulcer or stomach ulcer
- ☐ acid reflux, GERD
- ☐ GI bleed
- ☐ other: _____
- ☐ diverticulitis
- ☐ irritable bowel
- ☐ inflammatory bowel disease
- ☐ hepatitis - Type _____
- ☐ liver disease

Genitourinary Disorders

- ☐ urinary tract infection
- ☐ bladder problems
- ☐ kidney problems
- ☐ kidney stones
- ☐ dialysis, kidney failure
- ☐ other: _____

Metabolic & Other Disorders

- ☐ Diabetes x _____ years
- ☐ thyroid problems
- ☐ sickle cell disease
- ☐ high cholesterol or lipids
- ☐ skin disorder _____
- ☐ psoriasis
- ☐ any skin ulcer
- ☐ tooth abscess, gingivitis
- ☐ depression
- ☐ anxiety
- ☐ alcohol or drug dependency
- ☐ other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- ☐ asthma
- ☐ COPD or Emphysema
- ☐ heart attack, myocardial infarction
- ☐ irregular heartbeat, arrhythmia
- ☐ other heart :_____
- ☐ Peripheral neuropathy
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ acid reflux, GERD
- ☐ hepatitis - Type _____
- ☐ liver disease
- ☐ kidney problems
- ☐ diabetes
- ☐ thyroid problems
- ☐ Malignant hyperthermia
- ☐ tuberculosis
- ☐ other lung :_____
- ☐ MS or Parkinson's
- ☐ Lupus
- ☐ Other bone & joint: _____
- ☐ inflammatory bowel disease
- ☐ other GI :_____
- ☐ dialysis, kidney failure
- ☐ psoriasis
- ☐ sickle cell disease
- ☐ sleep apnea
- ☐ congestive heart failure
- ☐ bleeding problems
- ☐ other neuro :_____
- ☐ gout
- ☐ high cholesterol or lipids
- ☐ any skin ulcer

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

_____

_____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- ☐ Medicare
- ☐ Medicaid
- ☐ Blue Cross
- ☐ Blue Shield
- ☐ Major Medical
- ☐ Worker's Compensation
- ☐ Auto Accident
- ☐ Union Plan
- ☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

*Person to contact in an emergency (Name and Phone #):

_____

Primary Medical Doctor
Name: _____
Address: _____
Phone Number: _____

Work Information
Occupation: _____
Hours Worked per Week: _____

Major Medical or Auto Insurance(*if applicable*):

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone:
_____
Claim #: _____ Policy #: _____ Effective Date: _____

LEGAL INFORMATION(*if applicable*):

Attorney Name & Address:
_____
_____
Attorney Phone #: _____

We are always interested in working with friends and family members of our patients!

If you can think of anyone who may benefit from chiropractic care, please provide their information below and we'll be happy to provide them with a complimentary consultation, exam and x-rays.

Name: _____

Phone Number: _____

Email: _____

ADVANCED BACK & NECK PAIN CENTER

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES DR. RICHARD C. McKAY & DR. TRAVIS P. McKAY TO USE AND/OR DISCLOSE *PROTECTED HEALTH INFORMATION (PHI)* IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

☐ I give my permission to ADVANCED BACK & NECK PAIN CENTER to use my address, phone number and clinical records to contact me with birthday cards, newsletters and holiday related cards, Referrals & Thank you cards, In-office board and information about treatment alternatives or other health related information.

☐ I give ADVANCED BACK & NECK PAIN CENTER permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctors at any time in private, the doctor will provide a room for these conversations.

☐ By signing this form you are giving ADVANCED BACK & NECK PAIN CENTER permission to use and disclose your protected health information (PHI) in accordance with the directives listed above.

☐ I have received a copy Notice Privacy for Protected Health Information

EXPIRATION: The Authorization shall expire on the following date: 4/13/2017

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this Authorization, in writing, at any time. However, your written request to this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Advanced Back & Neck Pain Center. The written notice must contain the following information: Your name, SS#, date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature.

The revocation is not effective until the Privacy Official receives it. This AUTHORIZATION is not requested by ADVANCED BACK & NECK PAIN CENTER for its own use/disclosure of PHI.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ADVANCED BACK & NECK PAIN CENTER will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used-disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED UPON REQUEST**

Print Name of Patient: _____ Date: __/___/____

Signature of Patient: _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act for Patient: _____