Welcome To Our Office

New Patient Registration

Date: ________ Dr. ________ Case Number: ________

Full Name: ________ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Address: ________ Injury/Illness Date: ________

City: ________ State: ____ Zip: ____ Date of Birth: ________

Employer: ________ Occupation: ________ Age: ________

Employer Address: ________ Home Phone: ________

City: ________ State: ____ Zip: ____ Work Phone: ________

Who referred you to our office: ________ Mobile Phone: ________

May we contact you by e-mail: ________ Social Security # ________

Student: ☐ Full Time ☐ Part Time School: ________ Driver's License # ________

Spouse

Name: ________ Employer: ________ Date Of Birth: ________

Employer Address: ________ Employer Phone: ________

City: ________ State: ____ Zip: ____ Social Security # ________

Insurance

☐ Auto Accident ☐ Work Injury ☐ Group ☐ Medicare ☐ Other: ________

Primary Insurance: ________ Insurance Phone: ________

Insured's Name: ________ ☐ Male ☐ Female Insured's Phone: ________

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's DOB: ________

Insurance Address: ________ Insured's ID # ________

City: ________ State: ____ Zip: ____ Policy / Group# ________

Secondary Insurance: ________ Insurance Phone: ________

Insured's Name: ________ ☐ Male ☐ Female Insured's Phone: ________

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's DOB: ________

Insurance Address: ________ Insured's ID # ________

City: ________ State: ____ Zip: ____ Policy / Group# ________

Health Information

Reason For Your Visit: ________

Other Doctors' Seen For This Condition: ________ Response: ________

Symptoms Started: ________ Is It Getting Worse: ☐ yes ☐ no Pregnant: ☐ yes ☐ no

Have You Had This In The Past: ☐ yes ☐ no Explain: ________

Is It Painful To: ☐ Sit ☐ Walk ☐ Bend ☐ Stand ☐ Lie Down ☐ Lift Objects

Does It Interfere With: ☐ Work ☐ Exercise ☐ Sleep ☐ Daily Routine ☐ Recreation

Do You Take: ☐ Muscle Relaxers ☐ Pain Killers ☐ OTC ☐ Other ________

Have You Been Treated By A Chiropractor Before: ☐ yes ☐ no Explain: ________

List Medical Conditions and Surgeries: ________

Patient Agreement

Assignment & Release To Doctor: ________

1. You are authorized to **release any information** you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I hereby authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of any proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. I hereby authorize the **use of this signature** on all my insurance submissions.

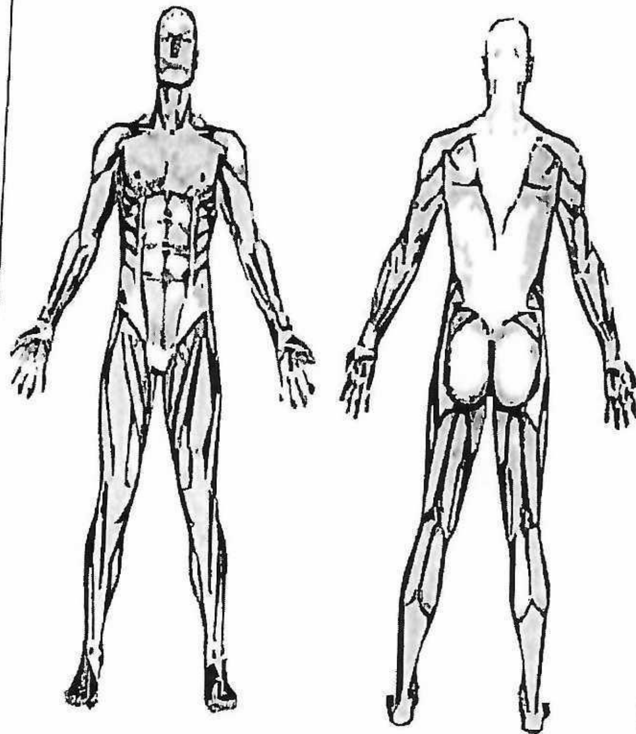
Signature Of Insured: ________ Date Signed: ________

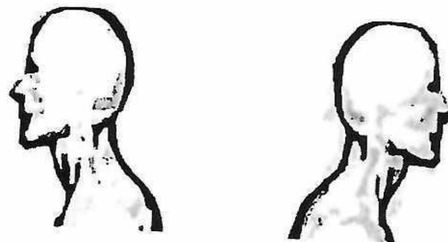
© 2001-2008 DoctorsDataSource.com

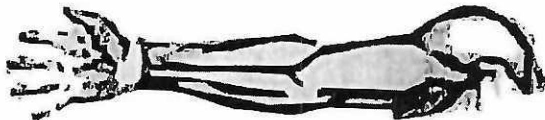
Have you ever suffered from:
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Breast Lump
☐ Bronchitis
☐ Bruise Easily
☐ Cancer
☐ Chest Pain/Conditions
☐ Cold Extremities
☐ Constipation
☐ Cramps
☐ Depression
☐ Diabetes
☐ Digestion Problems
☐ Dizziness
☐ Ears Ring
☐ Excessive Menstruation
☐ Eye Pain or Difficulties
☐ Fatigue
☐ Frequent Urination
☐ Headache
☐ Hemorrhoids
☐ High Blood Pressure
☐ Hot Flashes
☐ Irregular Heart Beat
☐ Irregular Cycle
☐ Kidney Infection
☐ Kidney Stones
☐ Loss of memory
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Lumps In Breast
☐ Neck Pain or Stiffness
☐ Nervousness
☐ Nosebleeds
☐ Pacemaker
☐ Polio
☐ Poor Posture
☐ Prostate Trouble
☐ Sciatica
☐ Shortness of breath
☐ Sinus Infection
☐ Sleep problems or Insomnia
☐ Spinal Curvatures
☐ Stroke
☐ Swelling of ankles
☐ Swollen Joints
☐ Thyroid Condition
☐ Tuberculosis
☐ Ulcers
☐ Varicose Veins
☐ Venereal Disease
☐ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing







© Copyright 2005 ChiroMatrix

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes | If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)!

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

© Copyright 2005 ChiroMatrix

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors for Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to fractures, disc injuries, dislocations and muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have associated with injuries to the arteries of the neck, leading to, or contributing to serious complications including stroke. HOWEVER THESE ARE VERY RARE. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment, during the course of the procedures, which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with the office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

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

Baek's Chiropractic Health Center INC.
Dr. Alex Baek D.C.
Dr. Tony Tang D.C.
13801 Roswell Ave. Suited G
Chino, CA 91710
(909) 548-6868

Do not sign until you have read and understand the above.

Printed Name of Patient: ______________________________
Signature of Patient: ______________________________ Date: __________
Signature of Patient's Representative: ______________________________ Date: __________
Witness of Patient's signature: ______________________________ Date: __________
Translated By: ______________________________ Date: __________
Date: __________

Baek's Chiropractic Health Center
13801 Roswell Ave. Ste. G
Chino CA 91710

909-548-6868

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting ***Baek's Chiropractic Health Center, Inc.***

Our **Notice of Privacy Practices** Describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

______________________________ ____________
Patient or Legally Authorized Individual Signature Date

______________________________ ____________
Print Patient's Full Name Time

______________________________ ____________
Witness Signature Date

Staff Notation:

This Form will be retained in your medical record.

HIPAA ACKNOWLEGEMENT

Baek's Chiropractic Health Center

AGREEMENT

To Office Policy and Rules

1. I agree to the following appointment schedule, I understand that I will be expected to make up any missed appointments must be made up within seven (7) days.

2. I agree to follow all other recommendations made by the doctor(s).
3. I understand that any recommendation for future care will be made only after physical and/or X-ray reexamination.
4. I agree to make a personal financial agreement and promptly fill out all necessary medical legal and insurance forms to aid in the timely payment for my care.
5. I understand that if my insurance company has not paid my claim within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow up on my status of payment.
6. I understand that each day I will be given Chiropractic/Acupuncture pamphlet to read before any treatment is rendered.

____
Signature of Responsible Party or Guardian

____
Date

____
Patient's name if other than responsible party

HEALTH THROUGH ADVANCED CHIROPRACTIC/ACUPUNCTURE

ADDS YEARS TO YOUR LIFE AND LIFE TO YOUR YEARS