File #_____

JOHNSON CHIROPRACTIC HEALTH & WELLNESS
REGISTRATION & HISTORY

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_____

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 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?_____

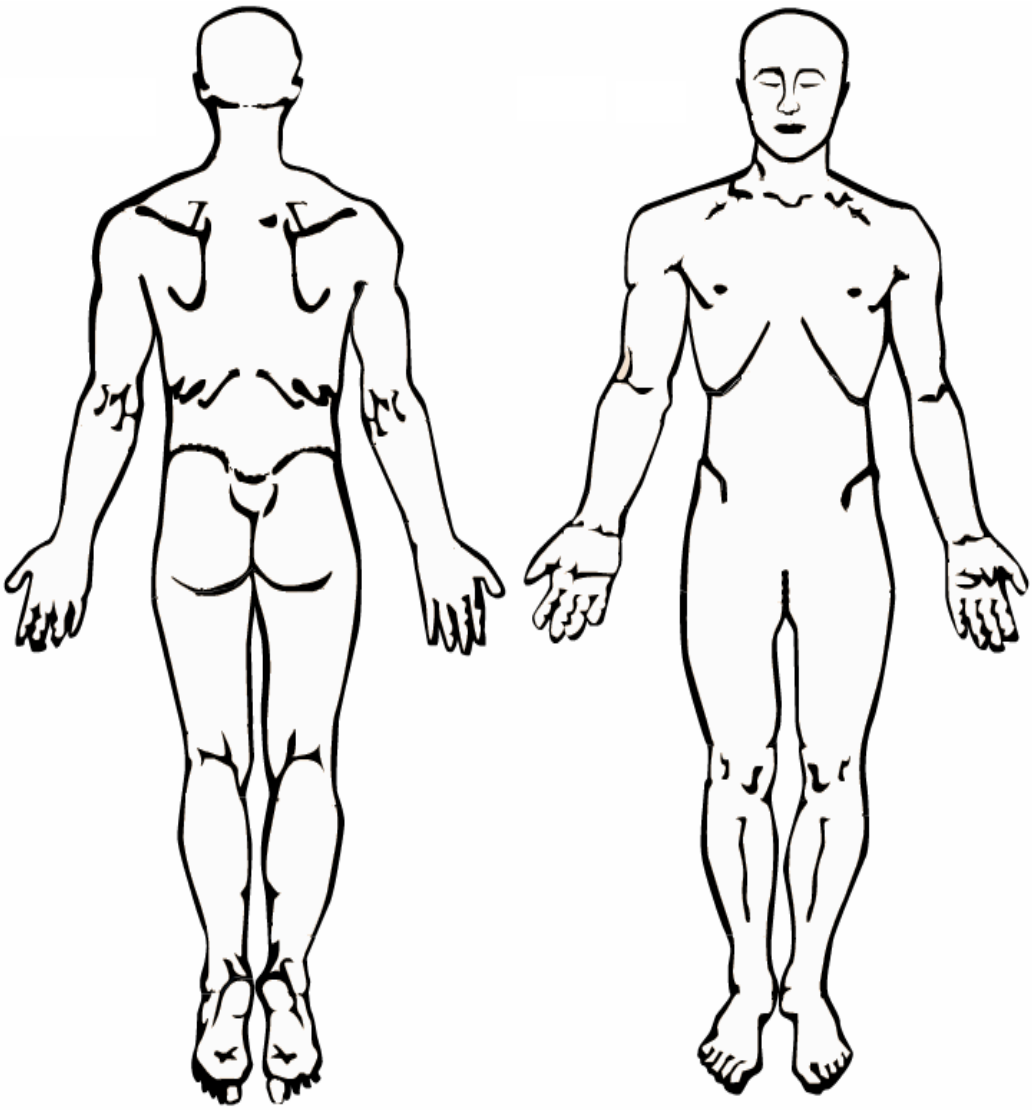
Does it interfere with:

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	

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

Are you pregnant? Yes_____ No_____ Due Date_____

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

Falls:_____

Head Injuries:_____

Broken Bones:_____

Dislocations:_____

Surgeries:_____

Other:_____

WHAT ARE YOU DOING FOR YOUR INJURIES:

_____

_____

_____

WHAT HAS WORKED BEST FOR YOU:

_____

_____

MEDICATIONS

Name of Medication Dosage Amount Prescribing Doctor

_____

_____

_____

_____

ALLERGIES

_____

_____

VITAMINS / HERBS / MINERALS

_____

_____

Pharmacy Name_____ Pharmacy Phone_____

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

_____ Chiropractic
_____ Medical Wave Pressure Therapy
_____ Ultrasound Therapy
_____ Electrical Muscle Stimulation Therapy
_____ Acupuncture
_____ Postual ReEducation
_____ Massage Therapy
_____ Chronic Pain Education
_____ Nutrition Supplements
_____ Diet / Nutrition Counseling
_____ Consultation for Treatment Options
_____Sports Physicals
_____Stretching / Strengthening Exercises
_____Heat / Cold Therapy
_____Physiotherapy
_____Itersegmental Traction Therapy
_____ Reflexology / Soft Tissue Trigger Point Release
_____ CBD Oil
_____ Health and Wellness Aids and Products
_____ 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:_____