MONTOWESE CHIROPRACTIC CENTER, LLC

Today's Date	**REGISTRATION FORM**

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Sex ☐Male☐ Female	Birthdate

Marital Status ☐Single ☐Mar☐ Div ☐Sep ☐Wid	Soc. Sec. #	Home Phone #	Cell Phone #

Street address	City	State	Zip Code

Email address:	Appointment Reminder ☐Text ☐ Voice

Occupation	Employer (with address)	Employer Phone #

Primary Care Physician	Address	MD Phone #

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone #	Cell phone #

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Primary Insurance	Policy #

Subscriber's Name	Subscriber's Social Security #	Birthdate:

Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary insurance	Policy #

Subscriber's Name	Subscriber's Social Security #	Birthdate:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Montowese Chiropractic Center, LLC. I understand that I am financially responsible for any balance. I also authorize Montowese Chiropractic Center, LLC to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

Above information reviewed with no changes:

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

MONTOWESE CHIROPRACTIC CENTER, LLC
MEDICAL HISTORY

Name:_____ Date:_____

Name of Referring Physician: _____

Patient's Occupation: _____

Condition Related to: ☐ Illness ☐ Employment ☐ Auto ☐ Other Date of Injury/Accident:_____

What are your present symptoms and when did they start? _____

_____

On a scale of 1 to 10 how would you rate your symptoms?
☐1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐6 ☐ 7 ☐ 8 ☐9 ☐ 10

Do you have:
PAIN ☐ TINGLING ☐ NUMBNESS ☐ DIZZINESS ☐

How would you describe it:
☐SHARP ☐DULL ☐THROBBING ☐BURNING ☐ACHING ☐CONSTANT ☐INTERMITTENT ☐OTHER

Please check if any of these are applicable to you:

☐Arthritis	☐Headaches	☐Peripheral neuropathy
☐Asthma	☐Heart Disease	☐Repeated infections
☐Blood disorders	☐Hypertension	☐Skin diseases
☐Broken bones/fractures	☐Infectious disease (e.g. TB, hepatitis)	☐Stomach problems/ulcers
☐Cancer	☐Kidney problems	☐Stroke
☐Depression	☐Low Back Pain	☐Thyroid problems
☐Developmental/growth problem	☐Multiple Sclerosis	☐HIV/AIDS
☐Diabetes	☐Muscular dystrophy	☐Are pregnant?
☐Emphysema	☐Osteoporosis	☐Use tobacco?
☐Head injury	☐Parkinson's Disease	☐Have a pacemaker/defibrillator?

What makes your symptoms better? _____ worse?_____

Are you allergic to latex or adhesives? ☐Yes ☐ No Other, please list_____

Have you recently had an x-ray or other diagnostic test? ☐Yes ☐ No

If yes, please list tests and where they were done?_____

_____

What kind of surgeries have you had? _____

Date of Surgery? _____

Have you received chiropractic care before? ☐Yes ☐No If yes, when?_____

Where?_____

Any other comments, problems?_____

*******IF YOU TAKE ANY MEDICATIONS, PLEASE FILL OUT THE MEDICATION LIST*******

MONTOWESE CHIROPRACTIC CENTER, LLC
MEDICATION LIST

Prescription Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

Over-the Counter Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

Herbal/Vitamin/Mineral/Dietary Supplements

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, intramuscular)

MONTOWESE CHIROPRACTIC CENTER, L.L.C.

Consent for Use or Disclosure of Health Information

The effective date of this privacy notice is April 14, 2003

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

Montowese Chiropractic Center, LLC

202 State Street
North Haven, CT 06473
203-985-1577
Fax 203-239-4290

2334 Whitney Avenue
Hamden, CT 06518
203-985-1577
Fax 203-239-4290

Dr. David Mikos, DC, PT, MCTA

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

PATIENT: _____ _____ _____
Printed Name Signature Date

WITNESS: _____ _____ _____
Printed Name Signature Date