

DRAGON'S LIFE SYSTEMS

ACUPUNCTURE | CHINESE MEDICINE | CHIROPRACTIC

Email: dragonslivesystems@yahoo.com • Website: www.dragonslife.com

PATIENT REGISTRATION FORM CHIROPRACTIC CARE

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____

Single Married Widowed Separated Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

How did you hear about us? Search Engine Yellow Pages Website Walk-in or Drive-by

Insurance Company Friend or Family Doctor Other

Who? _____ Who? _____

PHONE NUMBERS

Home: _____ Work: _____ Ext: _____

Email Address: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext: _____



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INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

And assign directly to Dr. _____ all insurance 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 insurance submissions.

Responsible Party Signature

Relationship Date

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): _____



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PATIENT CONDITION

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 Other

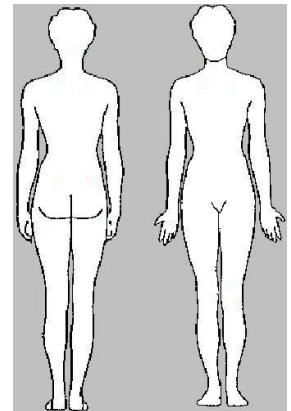
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing

Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery

Physical Therapy Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for you condition: _____

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:

AIDS/HIV Yes No Emphysema Yes No Miscarriage Yes No Scarlet Fever Yes No

Alcoholism Yes No Epilepsy Yes No Mononucleosis Yes No Stroke Yes No

Allergy Shots Yes No Fractures Yes No Multiple _____ Suicide Attempt Yes No

Anemia Yes No Glaucoma Yes No Sclerosis Yes No Thyroid _____

Anorexia Yes No Goiter Yes No Mumps Yes No Problems Yes No

Appendicitis Yes No Gonorrhea Yes No Osteoporosis Yes No Tonsillitis Yes No

Arthritis Yes No Gout Yes No Pacemaker Yes No Tuberculosis Yes No

Asthma Yes No Heart Disease Yes No Parkinson's _____ Tumors, _____

Bleeding _____ Hepatitis Yes No Disease Yes No Growths Yes No

Disorders Yes No Hernia Yes No Pinched Nerve Yes No Typhoid Fever Yes No

Breast Lump Yes No Herniated Disk Yes No Pneumonia Yes No Vaginal _____

Bronchitis Yes No Herpes Yes No Polio Yes No Infections Yes No



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Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High		Prostate		Venereal	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping	
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid		Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine		Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Due Date _____	
Injuries/Surgeries you have had		Description	Date
Falls		_____	_____
Head Injuries		_____	_____
Broken Bones		_____	_____
Dislocations		_____	_____
Surgeries		_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____

INFORMED CONSENT

Dear Patients:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage, therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause disc problem if the disc is in a weakened condition. These problems occur rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.



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Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will be able to assist you with your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient Name (Printed)

Date

Patient Signature

Parent or Guardian Signature for Minor

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize Dragon's Life Systems, Inc. to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day health care operations of Dragon's Life Systems, Inc. (including appointment reminder cards and confirming appointments at home or work)

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Dragon's Life Systems, Inc. reserves the right to change the terms of this notice from time to time and that I may contact Dragon's Life Systems, Inc. at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (Printed)

Date

Patient Signature

Parent or Guardian Signature for Minor