Alta Vista Chiropractic
1781 W 9000 S West Jordan, UT 84088 Tel: (801) 562-5600 Fax: (801) 255-7104

REGISTRATION

Patient First Name _____Middle Initial_____ Last Name _____
Street Address_____
City_____ State_____ Zip_____
Social Security #_____-____-_____ Sex ❑ M ❑ F ❑Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Age_____ Birth date_____/_____/_____ Email_____@_____
Primary Phone (____)_____ ❑H ❑W ❑ C Secondary Phone (____)_____❑H ❑W ❑ C
How/ who did you learn about this clinic? ❑Work._____ ❑Family/Friend_____❑Other _____
Relationship to Insured ❑ Self ❑Spouse ❑ Child ❑ Other
Condition/ Illness Related To ❑ Illness ❑Employment ❑ Auto ❑ Other

YOUR EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____❑ Full-time ❑ Part-time City _____ State _____ Zip _____Years Employed_____
POLICY HOLDER INFORMATION	❑ Same as above/ Name_____ First Name Middle Initial Last Name Birth date _____/_____/_____ Employer Name_____
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: _____ID #:_____ **PLEASE GIVE CARD TO FRONT DESK**
SECONDARY INSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: _____ID #:_____ Insured's Date of Birth:_____/_____/_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Alta Vista Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

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PD _____cc ca ck cr
COUPON _____
TOTAL=_____
Notes:

CHIEF COMPLAINT

My chief complaint is due to:
Auto accident ____ Work related injury ____ Other ____

Please list your main areas of concern:

A._____ B. _____

C._____ D._____

Please describe the type of pain you are experiencing in each area (aching, burning, stabbing, pins and needles, numbness, sharp, shooting, stinging, throbbing, dull, pounding, excruciating)

A._____ B._____ C._____D._____

Is your pain constant, frequent, intermittent, occasional?

A._____ B._____

C._____ D._____

How long have you had this problem or concern?

A._____ B._____

C._____ D._____

What were you doing when the problem started?

A._____ B._____

C._____ D._____

Is there a time of day your pain is:

Worse		**Better**	
A. Day/Night	B. Day/Night	A. Day/Night	B.Day/Night
C. Day/Night	D. Day/Night	C. Day/Night	D. Day/Night

What seems to make it better or comfortable?

A._____ B._____

C._____ D._____

What seems to make your symptoms worse or uncomfortable?

A._____ B._____

C._____ D._____

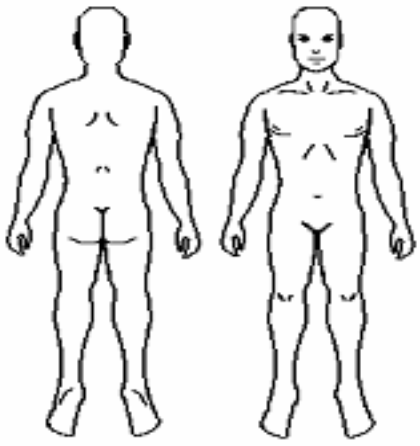
How is this problem affecting your life at home, school, work & sleep?

_____

Does your pain radiate to other areas of your body? If so, where?

_____

Please mark on the diagrams below where you are experiencing pain.



Please rate your pain.
My pain today is: (please circle one)

No pain Worst pain
0 1 2 3 4 5 6 7 8 9 10

My pain over the past week has been: (please circle one)

No pain Worst pain
0 1 2 3 4 5 6 7 8 9 10

Name_____ Date_____

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GENERAL HEALTH HISTORY

Have you had problems in the past with any of the following health issues?

Anemia	❑ Yes	❑ No	Eating Disorder	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Bleeding Disorder	❑ Yes	❑ No	Blood Clot in Leg or Lung	❑ Yes	❑ No
Stomach/Duodenal Ulcers	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Cancer or Tumor	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No
Thyroid Problem	❑ Yes	❑ No	Kidney/Bladder Disease	❑ Yes	❑ No
Colitis	❑ Yes	❑ No	Mental Illness	❑ Yes	❑ No
Convulsions or Seizures	❑ Yes	❑ No	Migraine Headaches	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No

FAMILY HEALTH HISTORY

Has anyone in your immediate family had any of the following

Arthritis	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No
Blood Disease/Clots	❑ Yes	❑ No	Mental Illness	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Location: _____		
			_____		

PAST HOSPITALIZATIONS/SURGERIES/TRAUMAS

Year	Operation/Illness/Trauma (LAST 10 YEARS)

MEDICATIONS

List all medication you are taking now including those you buy without a doctor's prescription (i.e., aspirin, cold tablets or vitamins).

1._____ 3._____ 5._____

2._____ 4._____ 6._____

ALLERGIES AND SENSITIVITIES

List anything you are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollen, bee stings, indicate how each affects you.

Allergic To: Reaction: Allergic To: Reaction:

1._____ 3._____

2._____ 4._____

SOCIAL HISTORY

Are you a student?	❑ Yes	❑ No	Do you consume alcohol?	❑ Yes	❑ No
Do you work?	❑ Yes	❑ No	Do you drink coffee/tea/soda?	❑ Yes	❑ No
Do you smoke cigarettes?	❑ Yes	❑ No	Do you exercise 2+ times/week?	❑ Yes	❑ No
Height_____			Weight_____		

Name_____ Date_____

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PATIENT RESPONSIBILITIES

Your co-pay is due at the time of service unless other arrangements have been made.

Please be advised that we collect a $50 no show fee if you have not given us 24 hour notice of cancellation for trigger point therapy and massage.

You will be personally responsible for this payment.

I, _____, a patient being treated at Alta Vista Chiropractic do hereby acknowledge that a certain portion of my care may not be covered by my health plan.

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Procedure:	Charge:
Massage Therapy codes not covered by Insurance	$
97124	$
	$
	$
(optional) ART codes not covered by insurance	$ 30 per 20 minutes

I acknowledge that I have been told in advance of treatment what portion of my care I will have to pay for.

Patient's signature: _____ Date: _____
(Guardian must sign for all patients 17 years or younger)

Witness: _____ Date: _____

If you have any questions or concerns, please ask at the front desk.

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DISCLOSURE & CONSENT CHIROPRACTIC ADJUSTMENT AND CARE

TO THE PATIENT: *You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make a decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Stephanie Allen, D.C., and/or other licensed Doctors of Chiropractic and Licensed Massage Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back up for Doctor Allen. I have the opportunity to discuss with Doctor Allen, or any other Doctor of Chiropractic in the clinic, my diagnosis, the nature and procedure of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injury, strokes dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts them known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment form my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print name

_____
Signature of patient

_____
Date Signed

To be completed by the patient's representative, if necessary: Additionally, I consent to allow any care recommended to be performed on my child or child under my legal guardianship.

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

As: _____
Relationship or authority of patient's representative

_____
Date Signed

To be completed by doctor or staff:

Witness to patient's signature: _____

Date: _____

Translated by: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been shown and have been given a copy of the
"NOTICE OF PRIVACY PRACTICES"
for Alta Vista Chiropractic

_____ _____
Signature Witness Signature

_____ _____
Date Date

The HIPAA information page is for the patient to keep if desired.

I give permission to_____, to have access to my medical records and to be able to discuss treatment and appointment times.