Morgan Chiropractic, Inc.
New Patient Registration Form

Patient Name: _____ Date: _____

PATIENT INFORMATION					
Patient Last Name:	First Name:	Middle Name:	Marital Status (select one) Other		
Date of Birth: ___/___/_____	Sex: ◯M /◯F	SSN:	Phone Number:	Email Address:	
Address:	City:	State:	Zip Code:		
Employer:	Job Title:	Secondary Phone Number:			

INSURANCE INFORMATION (Please have the front desk scan your Insurance card(s))		
Will you be utilizing health insurance for your care in our clinic? ◯ Yes / ◯ No (if no, please skip this section)		
Primary Insurance Company:	Subscriber's Name:	Employer:
Secondary Insurance Company:	Subscriber's Name:	Employer:
AUTO INCIDENT ONLY Insurance Name:	Claim Number:	

AGREEMENT TO PAY ANY BALANCES

In exchange for Morgan Chiropractic, Inc.'s forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board, and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgement, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer, or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all my indebtedness, I will remain liable to Morgan Chiropractic, Inc. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Morgan Chiropractic, Inc. are fully paid.

Patient or Guardian Signature:	**Date:**

CURRENT COMPLAINTS

Nature of Injury: ◯ Automobile Accident ◯ Work Incident ◯ Slip and Fall ◯ Other

Please briefly describe the injury:			
Date of Injury: _____ / _____ / _____	Date Symptoms Appeared: _____ / _____ / _____	Have you had this same condition? ◯ Yes / ◯ No	If yes, please explain:
Practitioners seen for this Injury/condition:			
Have you ever been under chiropractic care? ◯ Yes / ◯ No	If yes, briefly describe when and for what injuries/conditions:		

MEDICAL HISTORY

Have you been treated for any conditions in the last year? ◯ Yes / ◯ No	If yes, please describe:	
Date of last physical exam (estimate if necessary):	Are currently pregnant? ◯ Yes / ◯ No	If yes, when are you due?
Have you had X-rays taken in the last year? ◯ Yes / ◯ No	If yes, where and when?	
What medications are you currently taking? (Please include dosage and frequency)		
What vitamins, minerals, supplements, or herbs do you currently take? (Please include dosage and frequency)		

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New Patient Registration Form

HAVE YOU EVER:	YES	NO	PLEASE TELL US WHEN AND BRIEFLY DESCRIBE THE EVENT:
Broken any bones	◯	◯	
Been hospitalized	◯	◯	
Been in an auto accident	◯	◯	
Been struck unconscious	◯	◯	
Had surgery	◯	◯	

FAMILY HISTORY

Has anyone in your family (mother, father, grandparents, siblings, etc.) had any health conditions (Heart disease, Cancer, Diabetes, Arthritis…)

Please list:

PAIN AND SYMPTOMS

Do you experience pain every day? ◯ Yes / ◯ No	If yes, explain:
Do your symptoms interfere with daily life? ◯ Yes / ◯ No	If yes, explain:
Does pain wake you up at night? ◯ Yes / ◯ No	If yes, explain:
Are your symptoms worse during certain times of the day? ◯ Yes / ◯ No	If yes, explain:
Do changes in weather affect your symptoms? ◯ Yes / ◯ No	If yes, explain:
Do you wear orthotics? ◯ Yes / ◯ No	If yes, explain:

What activities aggravate your symptoms?

HABITS	NONE	LIGHT	MODERATE	HEAVY	OTHER (EXPLAIN)
Alcohol	◯	◯	◯	◯	◯
Coffee	◯	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯	◯
Drugs	◯	◯	◯	◯	◯
Exercise	◯	◯	◯	◯	◯
Sleep	◯	◯	◯	◯	◯
Appetite	◯	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯	◯
Water	◯	◯	◯	◯	◯
Salty or Sugary Foods	◯	◯	◯	◯	◯

REVIEW OF SYMPTOMS (Circle the following that apply to you)

Have you had any of the following constitutional issues? Chills Weight Gain Weight Loss Fatigue Daytime Drowsiness Night Sweats
Fever Other: _____ None of the above

Have you had any of the following eye issues? Blindness Eye Pain Double Vision Photophobia Tearing Blurred Vision Field Cuts
Cataracts Glaucoma Change in Vision Itchy Eyes Wear Contacts or Glasses Other: _____ None of the above

Have you had any of the following ENT (Ear Nose Throat) issues? Ear Drainage Ear Infections Hearing Loss Tinnitus Ear Pain TMJ
Frequent Nose Bleeds Loss of Smell Nasal Congestion Sinus Infections Rhinorrhea (runny nose) Post Nasal Drip Hoarseness
Difficult Swallowing Dental Implants Frequent Sore Throats Snoring Discharge Dizziness Fainting Headaches
Other: _____ None of the above

Have you had any of the following female issues? Birth Control Therapy Hormone Therapy Irregular Menstruation Severe Cramps
Breast Lump or Pain Abnormal Vaginal Bleeding or Discharge Burning Urination Frequent Urination Urine Retention
Other: _____ None of the above

Have you had any of the following male issues? Prostate issues Erectile Dysfunction Burning Urination Frequent Urination
Urine Retention Hestitancy or Dribbling Other: _____ None of the above

Have you had any of the following respiratory issues? Asthma Difficult Breathing COPD Emphysema Other: _____ None

Have you had any of the following cardiovascular issues? Heart Surgeries Congestive Heart Failure Murmurs or Valvular Disease
Heart Attacks or Mis Heart Disease Hypertension Pacemaker Angina Irregular Heartbeat Other: _____ None

Have you had any of the following gastrointestinal issues? Nausea Ulcerative Disease Frequent Abdominal Pain Hiatal Hernia
Constipation Bloody or Tacky Stools Pancreatic Disease IBS (Irritable Bowel Syndrome) or Colitis Hepatitis or Liver Disease
Vomiting Blood Bowel Incontinence Gastroesophageal Reflux or Heartburn Other: _____ None of the above

Have you had any of the following musculoskeletal issues? Rheumatoid Arthritis Osteoarthritis / Arthritis (unknown type) Gout Scoliosis
Spinal Fracture Spinal Surgery Joint Surgery Broken Bones Metal Implants Other: _____ None of the above

Have you had any of the following inegumentary (dermatological) issues? Significant Burns Significant Rashes Skin Grafts
Psoriatic Disorders Other: _____ None of the above

Have you had any of the following neurological issues? Vision Changes One Sided Weakness of Face or Body History of Seizures
Memory Loss Tremors Vertigo Loss of Taste or Smell Strokes or TIAs Other: _____ None of the above

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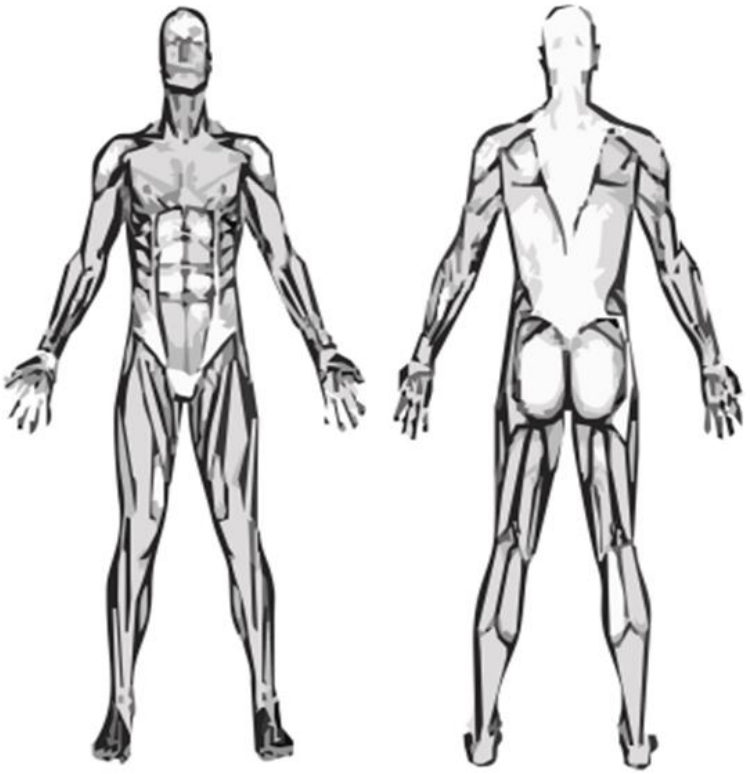
New Patient Registration Form

Have you had any of the following psychiatric issues? ☐ Depression ☐ Suicidal Thoughts ☐ Homicidal Ideations ☐ Schizophrenia ☐ Bipolar Disorder ☐ Psychiatric Diagnosis ☐ Psychiatric Hospitalizations ☐ Other: _____ ☐ None of the above
Have you had any of the following endocrine issues? ☐ Thyroid Disease ☐ Diabetes ☐ Hormone Replacement Therapy ☐ Steroid Replacements ☐ Other: _____ ☐ None of the above
Have you had any of the following hematologic/lymphatic issues? ☐ Anemia ☐ Regular Anti-inflammatory Use ☐ Abnormal Bleeding or Bruising ☐ HIV Positive ☐ Enlarged Lymph Nodes ☐ Hemophilia ☐ History of Blood Clots ☐ Anticoagulant Therapy ☐ Other: _____ ☐ None
Have you had any of the following allergic an immunological issues? ☐ Anaphylaxis ☐ Food Intolerance ☐ Other: _____ ☐ None
Have you had any of the following renal issues? ☐ Kidney Stones ☐ Kidney Disease or Damage ☐ Bladder Infections ☐ Hematuria (blood in urine) ☐ Difficulty Urinating ☐ Incontinence ☐ Dialysis ☐ Other: _____ ☐ None of the above
Is there anything else in your medical history that you feel is important to your care here?
I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Morgan Chiropractic, Inc. to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature:	Date:

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



Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:

Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

Area of pain:
_____
Level of pain (1 being the little to no pain): _____/ 10

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, induding demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

Patient Signature:	Date:

Email Notification Form (Optional)

First Name: _____ Last Name: _____

Email Address: _____

I, _____, agree to allow Morgan Chiropractic, Inc. to send me email notifications of office updates, events, or closures.

We will not give your email address to third parties. If at any time you wish to update your contact information or be removed from our email list, please email our office at morganchiro@gmail.com or call us at (907) 646-2211.

Patient Signature: _____ Date: _____