CORE
Spine & Rehabilitation Center LLC

Registration

Patient Information

_____ _____
(First, Middle, Last Name) *(Date of Birth)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Telephone Number) *(Work Telephone Number)* *(Cell Telephone Number)*

_____ _____
(E-mail) *(Social Security Number)*

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Sex: ❑ Male ❑ Female
Employment Status: ❑ Employed ❑ Part-time Student ❑ Full-time Student ❑ Other
Contact me for my next appointment by: Email / Text / My Cell Mobile provider is: _____

Employment Information

_____ _____
(Occupation) *(Employer)*

_____ _____
(Address) *(City, State, Zip Code)*

Spouse Information

_____ _____
(Name) *(Date of Birth)*

_____ _____
(Social Security Number) *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Responsible Person (If Applicable)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Phone Number) *(Social Security Number)* *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

_____ _____ _____
(Name) *(Phone Number)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

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Insurance Information

_____	_____	_____
(Name)	*(Date of Birth)*	*(Relationship to Patient)*
_____	_____	_____
(Insurance Company)	*(Group Number)*	*(ID Number)*
_____		_____
(Address)		*(City, State, Zip Code)*

How were you referred to our office?

- ❑ By an Attorney
- ❑ By a Doctor
- ❑ By a Patient
- ❑ Other

Please print the name of your source below.

_____

Is your illness or injury related to any of the following?

- ❑ Employment
- ❑ Emergency
- ❑ Accident
- ❑ Auto Accident

If Auto Accident, please print the state where the accident occurred below

_____

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature: _____ Date: _____

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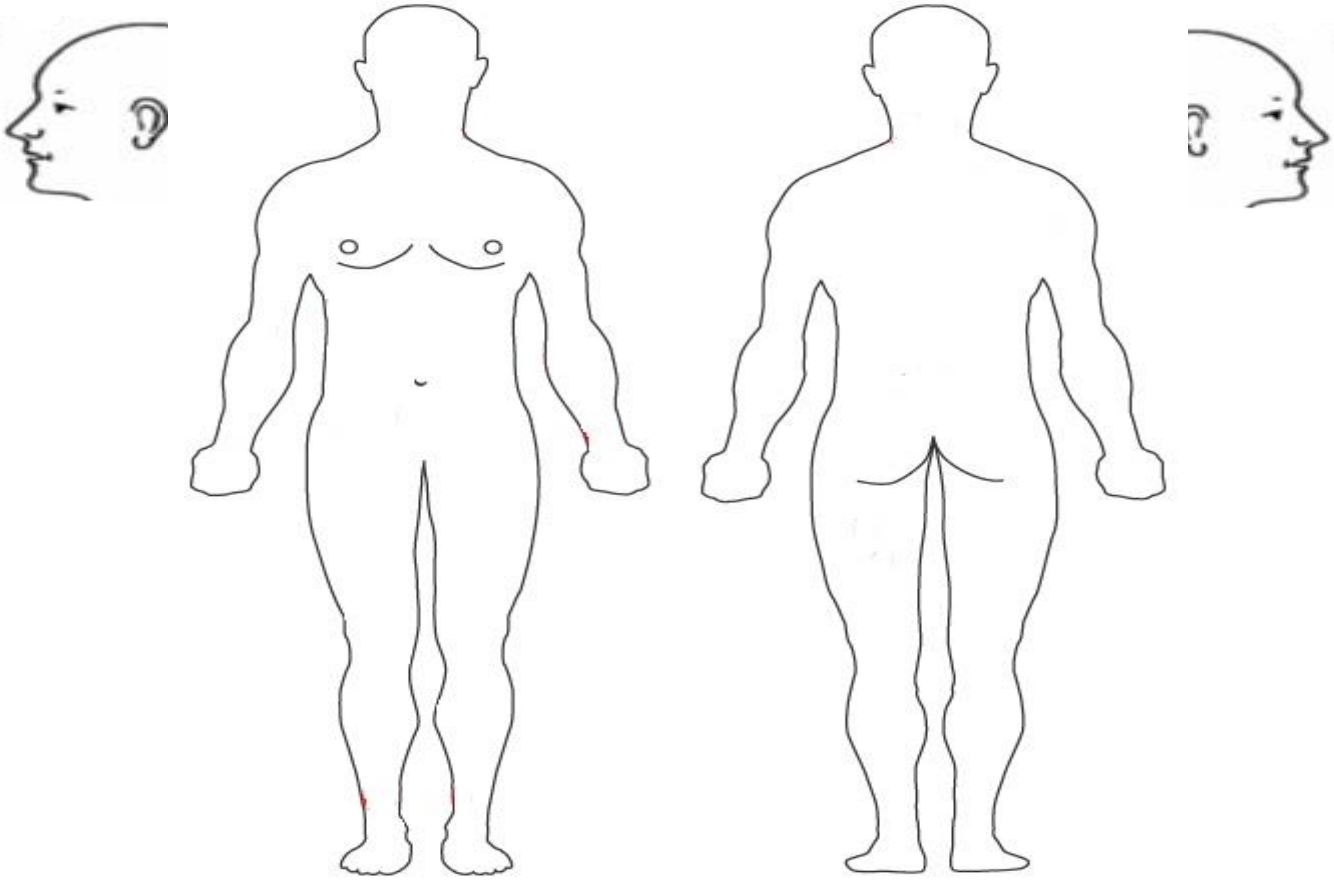
Place an **"X"** on the drawing below on areas causing you pain and a letter describing it.



A- Ache **B**- Burning **S**- Stabbing **N**- Numbness **P**- Pin and Needles

Pain Scale

Please circle the number that best describes your pain

0	1	2	3	4	5	6	7	8	9	10
	None			Little			Medium			Severe

5900 Argerian Dr. ● Ste#101 ● Wesley Chapel, Florida ● 813-373-5317 -Ph 813-373-5314 -Fax

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Medical Family History

Do you have chest pain?	Yes	No
Do you have indigestion?	Yes	No
Do you have headaches for hours or days?	Yes	No
Do you have blurred vision?	Yes	No
Do you have pain in neck, jaw or face?	Yes	No
Do you have vertigo (dizziness)?	Yes	No
Do you have any visual disturbances?	Yes	No
Do you have any ringing in your ears?	Yes	No
Do you pass out easily (faint)?	Yes	No
Do you take birth control pills?	Yes	No
Do you have a history of stroke in your family?	Yes	No

What prescription medication are you taking if any?

( ) High blood pressure medication

( ) Blood thinners

( ) Other_____

( ) List allergies or adverse reactions to medications _____

Have you ever had cancer?	Yes	No
Does your pain ever wake you from a sound sleep?	Yes	No
Have you had any loss of bladder or bowel control?	Yes	No
Have you lost consciousness or had double vision recently?	Yes	No
Are you seeing any other doctor now for any reason?	Yes	No

Note: _____

Are you taking any medications or over-the-counter drugs?	Yes	No

Please indicate type (aspirin, etc.) _____

What was the date of your last menstruation? _____

SOCIAL HISTORY

SMOKER ____YES or ____NO, If Yes, How many packs_____

ALCOHOL ____YES or ____NO, If Yes, How much_____

FAMILY HISTORY

Did you or your mother or father have any of the following:

Put an **S** for self**, M** for mother, **F** for father, and **A** for all

( ) High Blood Pressure	( ) Ulcer or Stomach Problems	( ) HIV Positive
( ) Heart Attack	( ) Stroke	( ) Pacemaker
( ) Emphysema	( ) Arthritis-Rheumatism	( ) Thyroid Disease
( ) Seizures-Convulsions	( ) Mental Illness	( ) Circulation Problems
( ) Asthma	( ) Diabetes	( ) Cancer
( ) Kidney Disease	( ) Osteoporosis	

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

(patient name please print) (date)

_____

(parent, guardian or patient's legal representatives name)

_____

(signature)

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

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Release of Patient Records Authorization

I hereby authorize _____to release a copy of my patient records or x-rays containing protected health information to:

CORE Spine and Rehabilitation Center LLC.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patients' legal representatives.

_____
(Patient's or Patient's Legal Representative's Signature)

_____ _____
(Patient's Date of Birth) (Date signed)

Specific description of information to be disclosed:

_____
_____
_____
_____

Release of Medical Information

I, _____, hereby authorize CORE Spine and Rehabilitation Center LLC. to release any medical information requested by representatives of local state or federal agencies, insurance companies, or other organizations or entities as may be required by said representative for payment of claims.

_____ _____
(patient/insured signature) (date)

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Financial Responsibility Statement

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment even though insurance companies have a fixed allowance or percentage based on your policy with them, **your policy is with your insurance company, not with this office**!
It is your responsibility to provide payment *for* the deductible, co-insurance, and any other balances not paid for by your insurance.
We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

Secondary Insurance _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

I authorize the release of all medical records needed to process this clam and that is pertinent to my medical care I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to **CORE Spine and Rehabilitation Center LLC**. This agreement 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 ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient: _____ _____
(If patient is a minor a parent's signature is required) (responsible party)

_____ _____
(witness) (date)

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Informed Consent for Chiropractic Care

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (the spine) and function (the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system s called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. A Chiropractic adjustment is the specific application of forces to correct and/or reduce the vertebral Subluxation. Our Chiropractic methods are very specific and usually done by hand, however they may be performed by handheld instruments also. In addition ancillary procedures such as physiotherapy and/or rehabilitation procedures may be included.

If during the course of care we encounter non-chiropractic or unsusual findings, we will advise you and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept Chiropractic care on this basis.

_____ _____
Print Name Signature

_____
Date

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of
Signature of Parent/Guardian
_____ have read and fully understand the above Informed
Name of minor or child
Consent and hereby grant permission for my child to receive Chiropractic care.