MARCUM CHIROPRACTIC/4310 N. Interstate Ave. Portland OR 97217/503-235-7130

REGISTRATION FORM

(Please Print)

Today's date:	Who referred you here?

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:	Home phone no.: ( )			
City:	State:	ZIP Code:	Cell phone no.: ( )			
Occupation:	Employer:	Employer phone no.: ( )				
Email: I prefer to receive specials offers and coupons by email ❑ post ❑						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate insurance:					
Subscriber's name: Subscriber's DOB:	Group no.:	Policy no.:	Co-payment:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **MARCUM CHIROPRACTIC** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

MARCUM CHIROPRACTIC CLINIC

4310 N. Interstate Ave. Portland OR 97217

HEALTH QUESTIONNAIRE

Note: PLEASE ANSWER EVERY QUESTION

If something does not apply to you put "NA". If you need help filling out this form please ask the receptionist.

Patient Name: _____ Date of Birth: _____

Date and Time of injury: _____

Chief complaints (describe symptoms, include location): _____

_____

_____

Is it ☐ constant ☐ comes & goes _____

Does it interfere with: ☐ work ☐ sleep ☐ daily routine ☐ recreation

☐ Headache	☐ Loss of memory	☐ Cold feet
☐ Neck pain/stiffness	☐ Fatigue	☐ Head feels too heavy
☐ Mid back pain	☐ Tension	☐ Diarrhea
☐ Low back pain	☐ Shortness of breath	☐ Constipation
☐ Pain in arms	☐ Irritability	☐ Stomach upset/pain
☐ Pain in legs	☐ Depression	☐ Blood in urine
☐ Eyes sensitive to light	☐ Difficulty concentrating	☐ Difficulty controlling urine stream
☐ Dizziness	☐ Sleep problems	☐ Chest pain
☐ Fainting	☐ Numbness in toes	☐ Nervousness/anxiety
☐ Ringing/buzzing in ears	☐ Numbness in fingers	☐ Cold sweats
☐ Nausea	☐ Pins & needles in arms	☐ Other:
☐ Loss of balance	☐ Pins & needles in legs	☐ Other:
☐ Loss of smell/taste	☐ Cold hands	☐ Other:

Are there any other areas of complaint? _____

_____

_____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes

When and for what? _____

_____

Date of last: Physical exam _____ Spinal exam _____

Breast exam/mammogram (women) _____ Prostate exam (men) _____

(Women only) Are you pregnant? ☐ No ☐ Yes

List all medication you are currently taking

MEDICATION	VITAMINS/HERBS/MINERALS
☐	☐
☐	☐
☐	☐
☐	☐

_____ _____

Patient Signature Date

Marcum Chiropractic Clinic
4310 N. Interstate Ave. Portland OR 97217 / 503-235-7130

Patient Consent Form

Patient Name: _____ **Date of Birth**: _____

___ I hereby authorize Marcum Chiropractic Clinic to release medical information regarding my current condition to my insurance company for purposes of payment and/or quality reviews; and to referring, consulting/treating physicians, or other medical providers as necessary to support continuation of care.

___ I authorize payment of insurance benefits to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. **I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be due immediately.

___ I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that if I want a more detailed account of how my Patient Health Information is going to be used in this office and my rights concerning those records, I can request and obtain a copy of the **HIPAA NOTICE** that is available at the front desk. I will inform the office if there is anyone that I do not want to receive my medical records.

___ I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens I may apply ice to the area (15 min. max.) and rest. If I am concerned about the discomfort or develop any new symptoms I can call **(503) 235-7130** to speak with the doctor. If I am unable to contact the doctor, I can present myself to an emergency department for evaluation/care.

___ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

___ I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the purpose of chiropractic adjustments and other procedures. I understand that, like in all forms of medicine, results are not guaranteed.

___ I further understand and am informed that as in all healthcare, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains, sprains, disc injuries and strokes. I expect the doctor to exercise judgment during the course of the procedure which the doctor believes at the time, based upon the facts then known, is in my best interests.

___ I have read the above consent with the doctor as indicated by my initials. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

I have read this form and understand its contents on this date. **Please initial each paragraph and sign.**

_____ _____ _____

Signature of Patient (or Guardian) **Date** **Todd J. Hartwig, M.S., D.C.**