MARCUM CHIROPRACTIC
4310 N Interstate Ave.
Portland, OR 97217
P: (503) 235-7130 F: (503) 235-7134
marcumclinic@gmail.com

# REGISTRATION FORM

(Please Print)

Today's Date: ______________ How did you hear about us? ____________________________________________

Patient Legal Last Name: ________________________ First: ______________________ Middle: ____________

Marital Status (circle): Single / Married / Divorced / Separated / Widowed

Date of Birth: ____/____/______ Age: _______ Sex: ☐ M ☐ F

Occupation: ____________________________________________________________________________

Street Address: ____________________________________ City: _______________ State: _______ Zip: ________

Social Security #: ___________________ Home Phone #: _________________ Cell phone #: ___________________

Email: __________________________________________

IN CASE OF EMERGENCY

Name of Emergency Contact: ______________________________________________________________________

Relationship to patient: _____________________ Home ph#: _________________ Cell ph#: ____________________

MOTOR VEHICLE ACCIDENT INFORMATION

(Complete boxed section ONLY if motor vehicle accident)

Date of Accident: ______/______/_______

Your Auto Insurance Company: __________________________________________________

Your Accident Claim Number: ___________________________________________________

Adjuster Name: ___________________________________________________________

Phone #: ______________________________ Fax#: ________________________________

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

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## Health Questionnaire

Note: Please answer every question
If something does not apply to you, put "N/A" -If you need assistance with the form, please ask the receptionist

Patient Name____________________________ Date of Birth____________
Date and Time of Injury________________________________________
Chief complaint(s) (describe symptoms and location on your body)
________________________________________________________
________________________________________________________
Is it constant? Comes and goes? ____________________________________

Does it interfere with (circle all that apply) Work? Sleep? Daily Routine? Recreation?

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

Are there any other areas of complaint?____________________________

Have you ever had chiropractic care of any other problem? No Yes

If so, when and for what injury____________________________________

Date of most recent physical exam? ____________ Spinal exam? ____________

Women only: Are you pregnant? No Yes

Please list all medications, vitamins, herbs, and/or supplements you are currently taking:

| Medication(s) | Vitamins/Herbs/Supplements |
|---|---|
| | |
| | |
| | |
| | |

X_________________________ ____________
Patient/Guardian Signature Date

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## BILLING & PAYMENT POLICY

For patients that do not have health insurance coverage, we offer a time of service discount, due at your appointment.
It is the patient's responsibility to ensure that payments mailed arrive on or before the payment due date.

Failure to make payments will result in the forwarding of your account to a collection agency.

## PATIENT RESPONSIBILITY DISCLAIMER

The patient is responsible for payment within a 30-day period.
The patient is responsible for contacting Marcum Chiropractic in the event that the account may require a payment plan.
You may make payments via telephone, by calling (503) 235-7130. You may also make payments in person, or write a check to:

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## CANCELLATION & NO-SHOW POLICY

Marcum Chiropractic aims to provide excellent care to our community of patients.
Our treatment plans set our patients up for success, and it is the patient's responsibility to make sure they attend their appointments.

As a courtesy to our providers and our other patients, Marcum Chiropractic **requires patients to give at least a 24-hour notice if they are unable to make it to their appointment.** Same-day cancellations will result in a **$25 fee, per provider (Chiropractic, Acupuncture, Massage)** due at next appointment or net-30 days from the original date of the appointment.

We understand that life happens. Your first last-minute/same-day cancellation is on us.
After that, your account will be charged a $25 fee, per provider as noted above.

**Please note that insurance companies will not cover your cancellation and no-show fees.**

I have read and understand the insurance billing, payment policy and the cancellation & no-show policy:

Signature: ______________________________ Date: ______________

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## PATIENT CONSENT

Patient Name (print): ______________________________ 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 directly 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 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 will be 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 to the doctor. If I am unable to contact the doctor, I can present myself to the 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 will have an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinical 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 as indicated by my initials. I will also have 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 treatments.

**I have read this form and understand its contents on this date.**

X______________________________ X__________________ ____________________________

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