Kruse Park Chiropractic Clinic

## NEW PATIENT REGISTRATION

Today's Date:__________ How did you hear about the clinic? ____________________

Name: ____________________________________________________________ Date of Birth: _____________

Last Name First Name Middle Initial **Gender**: M/F/NB/other

Address _______________________________________________________________________

Street City State Zip Code

Email Address:________________________ Main Phone Number:____________ SSN Number:____________

Emergency Contact: ______________________ Relationship:__________________ Phone#:________________

**RESPONSIBLE PARTY INFORMATION** (If Patient is a Minor)

Name:____________________________ Relationship to Patient:_____________________

Address (if different) :___________________________________________________________

Street City State Zip Code

Phone # (if different) :____________Date of Birth:___________ SSN#:_________

## INSURANCE INFORMATION

(Please present insurance cards for all coverage)

Primary Insurance Name:_____________________ Policy Holder Name:_____________________

Policy Holder DOB:_____________________ Policy Holder Employer:_____________________

Primary Insurance ID #:_____________________ Primary Insurance Group #:_____________________

Primary Insurance Claims Address:_____________________________________________

Secondary Insurance Name:_____________________ Policy Holder Name:_____________________

Policy Holder DOB:_____________________ Policy Holder Employer:_____________________

Secondary Insurance ID #:_____________________ Secondary Insurance Group #:____________________ Secondary Insurance Claims Address:_____________________________________________

## Please Initial Each Item Below

1. _______ I authorize Kruse Park Chiropractic Clinic to provide Chiropractic services to me.
2. _______ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Kruse Park Chiropractic Clinic.
3. _______ If my account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.
4. _______ I authorize any insurer to make payment for services rendered by Kruse Park Chiropractic Clinic directly to Kruse Park Chiropractic Clinic 3990 S.W. Collins way, Ste 201, Lake Oswego, OR 97035.
5. _______ I understand that there are two physicians in this office and I may receive treatment from either of the physicians if the other is unavailable. I may at any time, state a preference for one of the physicians.
6. ________ Please provide the name of your Primary Care Physician, (**7**.)____________________. I authorize my PCP to share health care information with Kruse Park Chiropractic Clinic if necessary.

By signing this application, I affirm under penalty of law that I have given true and complete information.

**Patients Signature:** ______________________________________________ **Date**: ______________________

**Responsible Parties Signature** (if patient is a minor) ____________________________________

Relationship __________________________________

## New Patient Questionnaire

Patient Name:______________________________________________________

D.O.B.______________________________________________ Gender MALE / FEMALE / NON BINARY / OTHER

Occupation: _____________________________________________________________________________

Number of Children?__________ How would you describe your health? ______________________

**MEDICAL AND SURGICAL HISTORY**

PLEASE LIST ANY PAST SURGERIES AND THE DATES OF EACH.

_____________________________________________ _______________________________________________

_____________________________________________ _______________________________________________

_____________________________________________ _______________________________________________

PLEASE LIST ANY PREVIOUSLY DIAGNOSED MEDICAL PROBLEMS.

_____________________________________________ _______________________________________________

_____________________________________________ _______________________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

| | YES | NO |
|---|---|---|
| HEART DISEASE | | |
| HIGH BLOOD PRESSURE | | |
| HEPATITIS/LIVER DISEASE | | |
| ASTHMA/EMPHYSEMA | | |
| POSITIVE TB SKIN TEST | | |
| HIGH BLOOD CHOLESTEROL | | |
| THYROID DISORDER | | |

| | YES | NO |
|---|---|---|
| ARTHRITIS | | |
| CATARACTS | | |
| GLAUCOMA | | |
| DIABETES | | |
| SEIZURES | | |
| ANEMIA | | |
| OTHER | | |

| | YES | NO |
|---|---|---|
| BREAST CANCER | | |
| OTHER CANCER | | |
| BROKEN BONES | | |
| STROKE OR TIA | | |
| TUBERCULOSIS | | |
| DEPRESSION | | |
| ALCOHOLISM | | |
| OSTEOPENIA/OSTEOPOROSIS | | |

PLEASE LIST ALL PRESCRIPTION (AND NON PRESCRIPTION) MEDICATIONS THAT YOU ARE TAKING AND THE DOSES.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES/NO

IF SO, WHAT MEDICATIONS ARE YOU ALLERGIC TO & WHAT REACTION DID YOU HAVE?

_____________________________________________________________________________________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING DURING THE PAST YEAR?

| | YES | NO |
|---|---|---|
| MARRIAGE | | |
| CHANGE OF RESIDENCE | | |
| DEATH OF SPOUSE | | |
| DEATH OF CLOSE FRIEND | | |

| | YES | NO |
|---|---|---|
| PERSONAL ILLNESS OR INJURY | | |
| MAJOR ILLNESS OR DEATH IN FAMILY | | |
| RETIREMENT OR JOB CHANGE | | |
| DIVORCE OR SEPARATION | | |

DO ANY OF THE FOLLOWING APPLY TO YOU?

| | YES | NO |
|---|---|---|
| BREAST LUMPS OR NIPPLE DISCHARGE? | | |
| DO A MONTHLY SELF-BREAST EXAM? | | |
| ABNORMAL VAGINAL OR MENSTRUAL BLEEDING? | | |
| TAKING BIRTH CONTROL PILLS OR ESTROGEN? | | |

## FAMILY HISTORY

DO YOU HAVE A BLOOD RELATIVE WITH ANY OF THE FOLLOWING? PLEASE INDICATE RELATIONSHIP TO PATIENT, FOR "YES" ANSWERS.

| | NO | YES, RELATION |
|---|---|---|
| BREAST CANCER | | |
| BOWEL CANCER | | |
| OTHER CANCER | | |
| DIABETES | | |
| ALCOHOLISM | | |
| DEPRESSION | | |

| | NO | YES. RELATION |
|---|---|---|
| HISTORY OF SUICIDE | | |
| HEART ATTACK | | |
| STROKE | | |
| HIGH BLOOD PRESSURE | | |
| THYROID DISEASE | | |
| OTHER | | |

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## HEALTH HABITS

DO YOU EAT A SPECIAL DIET? YES/NO IF YES, DESCRIBE________________________________

______________________________________________________________________________

DO YOU EXERCISE REGULARLY? YES/NO IF YES, HOW MANY TIMES PER WEEK? ___________

WHAT METHOD OF EXERCISE DO YOU USE? ____________________________________________________________

DO YOU SMOKE? YES/NO IF YES, WHAT AND HOW MUCH? _________________

HAVE YOU EVER SMOKED? YES/NO IF YES, WHEN DID YOU STOP? _________________

DO YOU CHEW TOBACCO? YES/NO IF YES, WHAT AND HOW MUCH? _________________

DO YOU DRINK ALCOHOL? YES/NO IF YES, WHAT AND HOW MUCH? _________________

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**DO ANY OF THE FOLLOWING APPLY TO YOU?** PLEASE INDICATE IF **CURRENT** (C) OR **PAST** (P).

| | C | P | | C | P |
|---|---|---|---|---|---|
| TROUBLE WITH EARS OR HEARING | | | TROUBLE WITH EYES OR VISION | | |
| DIFFICULTY URINATING/HOLDING URINE | | | CHEST PAIN OR HEAVINESS WITH ACTIVITY | | |
| TROUBLE SWALLOWING, CHEWING, HEARTBURN, STOMACH PAIN | | | SHORTNESS OF BREATH, PRONE TO COUGHING | | |
| LOST OR GAINED 10 POUNDS IN PAST YEAR WITHOUT TRYING | | | RECENT CHANGE IN BOWEL MOVEMENT OR BLOOD IN STOOL | | |
| BACK, JOINT, OR MUSCLE PROBLEMS | | | SEXUAL PROBLEMS YOU WISH TO DISCUSS | | |
| OTHER PROBLEMS WITH YOUR FEET | | | SWELLING OF FEET OR ANKLES | | |
| FREQUENT DIZZINESS | | | SEVERE HEADACHES | | |
| TROUBLE SLEEPING | | | TIRE EASILY | | |
| FALLEN TO GROUND IN PAST YEAR | | | TROUBLE WALKING OR LOSING BALANCE | | |

PLEASE ANSWER THE FOLLOWING QUESTIONS

| | YES | NO |
|---|---|---|
| IS THIS DUE TO A MOTOR VEHICLE ACCIDENT? | | |
| IS THIS DUE TO AN ON THE JOB INJURY? | | |
| HAVE YOU HAD ANY RECENT X-RAYS TAKEN? | | |
| IF YES, OF WHAT AREA, AND WHEN? | | |

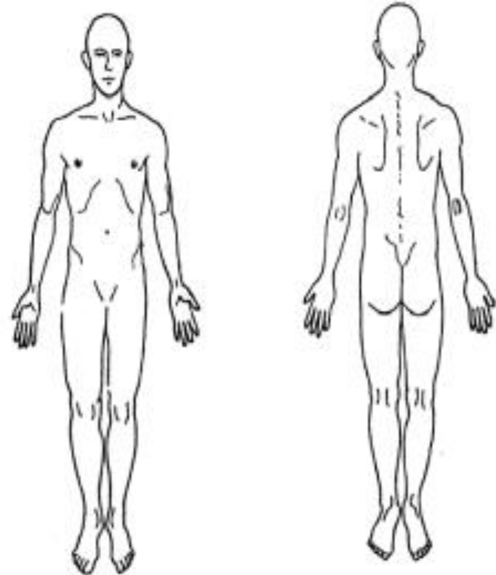
NAME OF YOUR PRIMARY CARE PHYSICIAN? ________________
DATE OF YOUR LAST PHYSICAL EXAM? _____________

HAVE YOU SEEN A CHIROPRACTOR PREVIOUSLY? YES or NO
IF SO, WHEN? _____________
FOR WHAT? ____________________________________

DO YOU WEAR (CIRCLE): HEEL LIFTS / SOLE LIFTS / INNER SOLES/ ARCH SUPPORTS / NEGATIVE HEELS / PLATFORM SHOES /ORTHOTICS

| DATE YOUR CURRENT SYMPTOMS APPEARED? | |
|---|---|
| WHAT ARE YOU CONCERNED ABOUT TODAY? | |

**TELL US WHERE YOU'RE HURT**: Mark the areas on your body where you feel pain. If your pain radiates, draw an arrow from where it starts to where it stops.
Use the symbols listed below.



| Ache | Burning | Numbness |
|---|---|---|
| >>>>> | xxxxx | ===== |
| Stabbing | Pins/Needles | Throbbing |
| ///// | 00000 | ~~~~~~ |

**How often are your symptoms present?**
(Please circle) 0-25% 26-50% 51-75% 76-100%

**SYMPTOM RATING SCALE**
Please circle the number that best describes your symptoms in each of the questions below.

What is your symptom intensity RIGHT NOW?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 = No Symptoms | | | | | | 10 = Unbearable Symptoms | | | | |

What is your WORSE symptom intensity?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 = No Symptoms | | | | | | 10 = Unbearable Symptoms | | | | |

In the past week, how much has your pain interfered with your daily activities?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0=unable to do anything | | | | | 10 = 100%, no interference | | | | | |

What is your TYPICAL or AVERAGE symptom intensity?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 = No Symptoms | | | | | | 10 = Unbearable Symptoms | | | | |

Doctor's Signature: ______________________________________ Date:________

**INFORMED CONSENT**

To our patients:
Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound therapy, heat application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.
These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name: ___________________________________________

Patient Signature: ________________________________________

Date: ______________________

**CLINIC ACCOUNT POLICY**

❖ Payment is expected at the time of service.

❖ As a service to you, we will bill your insurance company. If we can document your coverage, we will ask you to pay your co-pay, percentage, deductible, or non-covered service fee at the time of each visit.

❖ If your insurance policy requires a referral for chiropractic care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.

❖ We make every effort to get accurate information from your insurance company. At times, however, insurance companies give us inaccurate information. For this reason, we periodically review our accounts and may have to inform you of a balance due.

❖ Information received from the insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.

❖ If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.

❖ Personal injury accounts (automobile accidents) require that certain paperwork be filed by you with your insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you must pay at the time of service for your care and be reimbursed by any insurance company involved.

❖ If at any time you would like a copy of our fee schedule, please ask, we will be happy to provide you one.

**I have read and understand the above account policy**:
Patient Name: ______________________________________________________
Patient Signature: ______________________________________________________ Date: __________________________

**PRIVACY POLICY**

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this policy outlining our privacy practices.

We reserve the right to change this policy at any time, provided the applicable law allows the changes. These changes may apply to health information that was created or received before the changes were made. Before we make a significant change in our privacy practices, we will make the new policy available on request.

You may request a copy of this policy at any time. If you have questions, concerns or complaints about this policy or our privacy practices, please contact Dr. Illingworth at Kpccservice@kruseparkchiro.com

**USE AND DISCLOSURE OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. Examples include:

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing care to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your healthcare information in connection with our healthcare operations. Examples of healthcare operations include provider training, licensing or credentialing activities and quality assessment.

**Your Authorization**: In addition to the above uses of your healthcare information, you may give us written authorization to release your healthcare information to anyone at any time. You may also revoke this authorization at any time. Revocation of authorization would not affect any information that was released while the authorization was in effect. Unless you give written authorization, we cannot release your healthcare information for any reason other than those described above.

Your family and friends: Your healthcare information will not be released to your family and friends unless we have your specific permission.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location and/or general condition, if necessary. If you are able to authorize this contact, you will have the opportunity to do so. We will use our professional judgment and our experience with common practice to make reasonable decisions regarding your best interest in allowing a person to pick up your x-rays, supplies or records for you.

**Marketing**: We will not use your healthcare information for marketing purposes without your written authorization. Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or neglect, domestic violence or a victim of other crimes. This disclosure will be to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your healthcare information to provide you with appointment reminders (such as cards, phone messages or letters).

**PATIENT RIGHTS**

Access: You have the right to look at or gain access to your healthcare records. If you wish to have copies of your records, you must make that request in writing. You will be charged a minimum of $25.00 for these copies.

Amendment: You have the right to request that your health records be amended. This request must be in writing, along with an explanation for the amendment. All requests for an amendment must be approved by the treating physician and will be clearly marked in the file as a patient requested amendment.

Restrictions: You have the right to place additional restrictions on the use or disclosure of your health information. We may not be required to agree with the request for additional restrictions.

Disclosure accounting: You have the right to ask for a list of all instances of disclosure of your records, other than those disclosures for treatment, payment, healthcare operations or certain other purposes, after April 14, 2003.

QUESITONS AND COMPLAINTS

If you have questions, concerns or complaints regarding the handling of your healthcare information, please contact Dr. Bronwyn Illingworth, DC.
Telephone: 503-635-1236

*Thank you,*
*the KPCC team*