Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124
Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

NEW PATIENT REGISTRATION

Today's Date_______________

Name____ Acct#_______________ Int________
Last First Middle

(Complete Mailing)
Address____**
Street Apt# City State Zip

Social Security # ________ – ______ – ________ Date of Birth__________________

Home Phone # (_____)______–_______** Work Phone # (_____)______–_______**

Cell Phone # (_____)______–_______** E-mail Address: _________________________________**

Emergency Contact___________________ Relationship____________ Phone# (_____)______–_______

Employer_______________________ Occupation_________________ Phone# (_____)______–_______

Is this visit routine/accident/illness/other: _________________ If Accident (date) _________________

RESPONSIBLE PARTY INFORMATION

Name (Guarantor)____
Last First Middle

Relationship to Patient ____________________________

Address ____ Phone# (_____)______–_______
Street City State Zip

Employer___________________________

Address____ Phone #(_____)______–_______

Name of Insurance_______________________ ID#______________________Grp#________________

(please complete other side)

Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me

_________________________________ __________

Signature Date

Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124

Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. ______ I hereby authorize Carrier Chiropractic to provide Chiropractic Services for 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 at Carrier Chiropractic.

3. ______ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. ______ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Carrier Chiropractic, 3653 NW John Olsen Pl, Hillsboro, OR 97124.

5. ______ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _________day of _______________ 20_____.

____

Patient Signature

____

Guarantor Signature **Relationship to Patient**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

____ DOB ______________________

Patient's full name

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _______________ and expires _______________

Signature_______________________________________Witnessed by ____________________

(Parent or Guardian)

Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124
Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

PERSONAL HEALTH HISTORY

Patient's Name ____ **DOB** ________________ **Date** _________________

Clinician Scott Carrier, DC

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional **F = Frequent** **C = Constant**

O F C

Muscle / Joint
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain, stiffness
☐ ☐ ☐ Pain between shoulders

General
☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness, depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

Cardiovascular
☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heartbeat
☐ ☐ ☐ Slow heartbeat
☐ ☐ ☐ Swelling of ankles

Genitourinary
☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Lack of kidney control
☐ ☐ ☐ Kidney infection
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat
☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noise
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nose bleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

Gastrointestinal
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Bloated abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gallbladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

O F C

Skin
☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

Pain or numbness in
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hand
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

Respiratory
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

Women only
☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excess menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Lumps in breast
☐ ☐ ☐ Menopause
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Cancer
☐ Chicken pox
☐ Cholera
☐ Cold sores
☐ Diabetes
☐ Diptheria
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Herpes
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough

Describe chiropractic problem:____

____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No

Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)

What seemed to be the initial cause?

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _________
For what reason?

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124

Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐ Yes ☐ No
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Indicate the drugs do you now take? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify)
Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Do you use a bedboard? ☐ Yes ☐ No
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- had strains or sprains?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been struck unconscious?	☐	☐	
- been hospitalized for other than surgery?	☐	☐	
Do you:			
- take minerals, herbs or vitamins?	☐	☐	
- think you need minerals, herbs or vitamins?	☐	☐	
- have any drug allergy?	☐	☐	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

HABITS	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

____

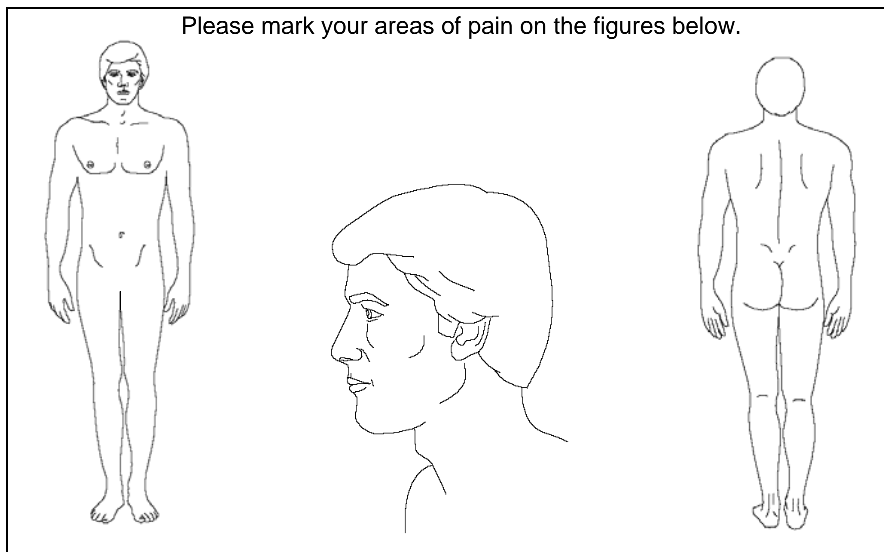
____

____

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124

Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

CONSENT FORM

To Our Patients:
Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, cold application, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. 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. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments 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 signature Date

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the chiropractic physician because it may affect care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Carrier Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

Carrier Chiropractic • 3653 NW John Olsen Pl. • Hillsboro, OR 97124
Phone: (503) 726-7260 • Fax: (503) 352-3271 • www.CarrierChiropractic.com

Clinic Financial Policy

1) We accept cash, Visa, MasterCard and Discover.
2) All payments are due at the time of service.
3) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
4) As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
5) If you have a credit balance, we will reimburse you after payment has been received.
6) All supplies **must** be paid for at the time they are received.
7) You are responsible for timely payment of your account.

Workers Compensation Claims

8) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

9) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been done.
10) Keep in mind we do not do third party billings to other insurance companies.
11) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
12) Generally supports and other supplies may not be covered by insurance companies, and must be paid for at the time they are received.

I have read, understand and agree with the above financial policy.

____________________________________ __________________
Patient/Guardian Signature Date