Welcome to Lighthouse Family Chiropractic Center!!!

Patient Name: ______________________________ **Date:** ______________

Address: ______________________________ **City:** ______________________

State: _______ **Zip:** ____________ **Home Phone:** ______________________ **E-mail:** ______________________

Marital Status: ________________ **# Of Children:** __________ **Social Security #:** ______________________

Birth date: ________________ **Sex:** ________**Age:** ________ **Height:** ______________ **Weight:** ______________

Do you Smoke: ☐ **Yes, current smoker** ☐ **Former smoker** ☐ **No, Never smoked**

In Case of Emergency contact: ______________________________ **Rel. to patient:** ____________________

Emergency Contact Phone: ____

Cell Phone #: ____________________________ **Cell Carrier: ATT Sprint Verizon T-Mobile Other:** ______________

<u>Primary</u> Insurance Co: ______________________________ **Ins. Phone#:** ______________________

Policy/ID#: ______________________________ **Group#:** ______________________

Primary insured name: ______________________________ **Birth date:** ___/_____/_____ **Rel. to patient**_______________

Address (if different than patient) ____

<u>Secondary</u> Insurance Co: ______________________________**Ins. Phone#:** ______________________

Policy/ID#: ______________________________ **Group#:** ______________________

Primary insured name: ______________________________ **Birth date:** ___/_____/_____ **Rel. to patient**_______________

Address (if different than patient) ____

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

For Women: Are you pregnant? ☐ No ☐ Yes (If yes, How many weeks? ___________________________)

Are you in pain: ☐ Yes ☐ No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/Play ☐ Auto Accident ☐ Routine/Household Activities

When did your condition/accident occur? ______/______/________ Where did your injury occur? ______________________________

Please explain what happened: ____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine? If so, how ______________________________

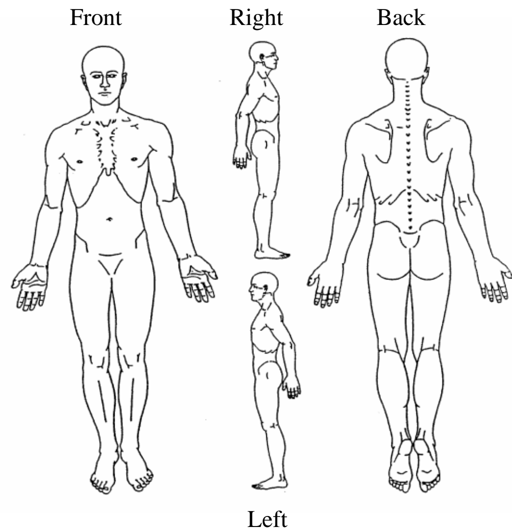
____

Has this or something similar happened in the past?

☐ Yes ☐ No Explain: ______________________________

____

Using the adjacent body charts, please circle all affected areas.



Have you been treated by a medical physician for this pain?

☐ Yes ☐ No If so, where? ______________________________

____

Have you been treated by a chiropractor? ☐ Yes ☐ No

Clinic or Dr's Name: ______________________________

Clinic Phone #: ______________________________

Are you taking any of the following medication?

☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Blood Thinners ☐ Tranquilizers

☐ Other(s)____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Vernereal Disease	Y N Hepatitis	Y N Anemia/Diabetes
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problems
Y N High/Low Blood Pressure	Y N Psychiatric problems	Y N Rheumatic Fever	Y N Severe/Frequent Headaches	Y N Tuberculosis
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Alzheimer's

Family Health History:____

____

Please list any Medication Allergies? ____

Please List all Current Medications: ____

____

____

Do you take Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ No ☐ Yes __________ hours per week

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ No ☐ Yes since ____/____/________

For Women: Are you taking Birth Control? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature____ Date ______/_____/_________

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

____

Dr. Notes: ____

____

____

____

____

____

Michael Schradin, DC
73 Nautilus Drive
Manahawkin, NJ 08050
609-597-4755

Patient Confidentiality

All records are confidential in nature, with the exception of the following. If you state that you intend to hurt yourself or another person, or disclose that a child or a vulnerable person is being abused this must be reported. Also, sometimes, patient records are subpoenaed by court. In addition, if you are seeking reimbursement through your insurance company, your signature gives permission to provide them with a diagnosis, treatment plan, date of service, and an evaluation of progress. For any other consultations, you will be provided with a separate consent form.

Cancellation Agreement

For cancelled appointments with out 24 hours notice or for missed appointments, I will be charged a fee of $40.00. I understand that I may call and leave a message to change or cancel an appointment any time of the day, including weekends and holidays.

Patient Liability Agreement

I/We understand that I/We am financially responsible for all bills incurred while under the care of Dr. Michael Schradin. DC. In the event that my/our account is not paid, I/We shall be liable for any and all costs of collection, including, but not limited to an additional 33.33% fee if my/our account is forwarded to a collection agency for collections. I/We further understand that there shall be 18% interest charged on any outstanding balance. In addition, I/We further understand that I/We, shall also be responsible for paying any reasonable attorney's fees plus court costs.

Informed Consent to Treat

Chiropractic Manipulation and Therapy Risks:
As with any healthcare procedure, there are certain complications which may arise during or after chiropractic manipulation of the spine/and or extremities and with the use of physical therapy treatments. These complications include but are not limited to: Fractures of bones, spinal disc injuries, joint dislocations, muscle injuries, nerve injury, worsening symptoms and rib injuries. These complications are generally described as rare. manipulation of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of are exceedingly rare and are estimated to occur between one in a million or more neck adjustments. Have been reading these risk factors, I hereby attest that I understand the terms used in the above paragraphs and give my consent for chiropractic treatment.

By signing below, I/We hereby indicate that 1) I/We have read this contract, 2) I/We understand the terms of this contract and 3) I/We agree to the terms of this contract.

______________________________	______________________________
Patient Name (Print)	Date
______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Parent/Guardian Signature	Date