To save yourself time, please print this packet and fill out information prior to your scheduled appointment. Once filled out, please call our office to confirm your appointment time.

Remember to bring packet with you to your appointment.

Thank you.

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

REGISTRATION
(PLEASE PRINT)

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

ALLERGIES To medications or substances

_____

_____

_____

_____

_____

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

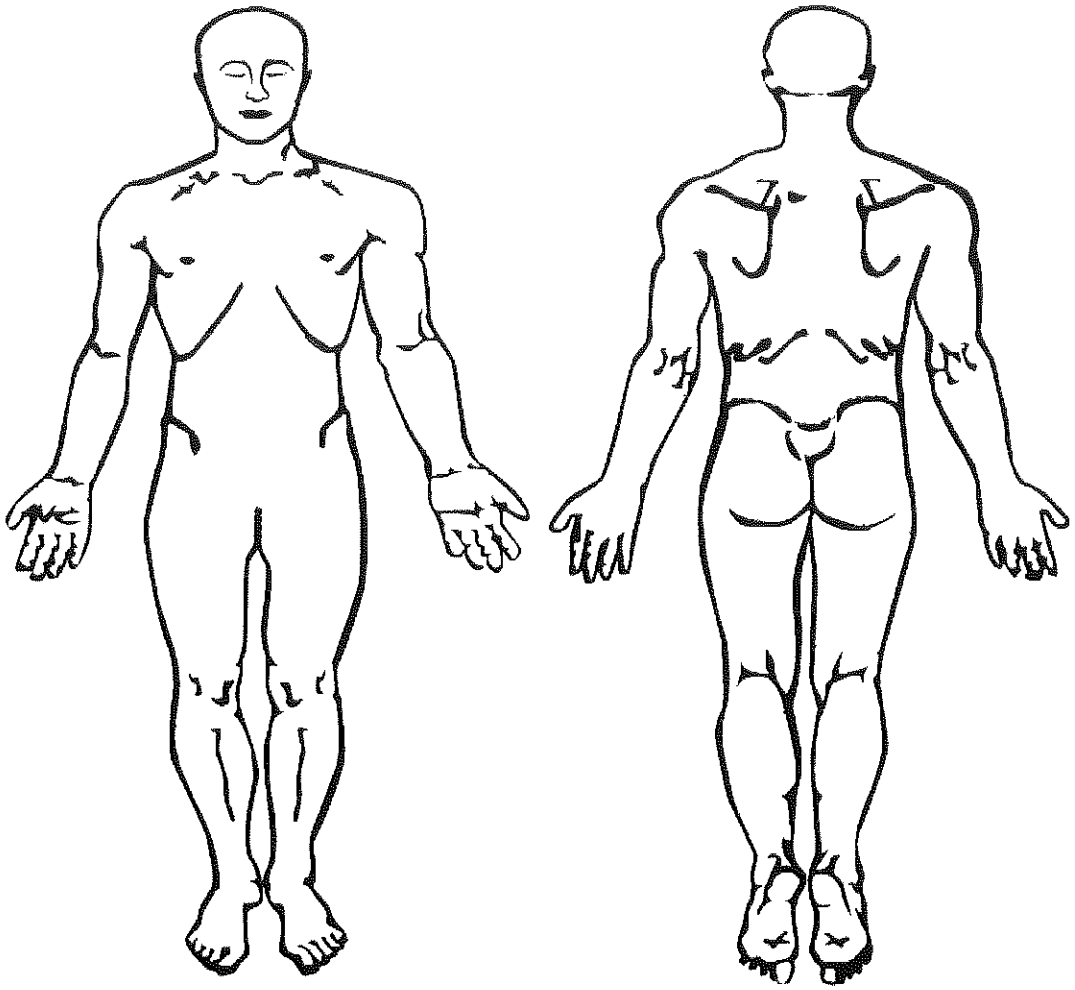
Reviewed By — Date

PAIN DIAGRAM

Date: _____ Name: _____

Use the body diagram below to indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
AAAA	====	OOOO	.....	////	xxxx
AAAA	====	OOOO	.....	////	xxxx



Instructions: Please circle the number that is associated with each complaint.

no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

527 Tunxis Hill Rd. Fairfield, CT 06825
T 203.333-7788 F 203.366-7566

Patient Questionnaire

Patient Name_____ Date_____

1. Do you ***currently*** experience any numbness/tingling/pins and needles in to your arms & hands or legs & feet?

Yes / No

2. Do you experience any numbness or tingling at ***any time*** during the day and/or during the night when in bed?

Yes / No

3. How long has it been since you have experienced any of these symptoms?

_____

Patient name: _____ Date: _____

☐ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.

☐ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

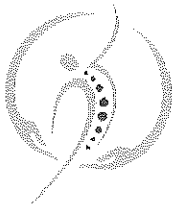
I am pregnant	_____Yes	_____No	_____Don't know
I could be pregnant	_____Yes	_____No	_____Don't know
My menstrual period is late	_____Yes	_____No	_____Don't know
I am taking oral contraceptives	_____Yes	_____No	
I have an IUD	_____Yes	_____No	
I have had a tubal ligation	_____Yes	_____No	
I have had a hysterectomy	_____Yes	_____No	
I have irregular menstrual periods	_____Yes	_____No	

My last menstrual period began _____

I have begun menopause _____yes _____no

An X-ray may be performed on me with my consent.

Signature:_____ Date: _____



iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

527 Tunxis Hill Road
Fairfield, Connecticut 06825
203.333.7788
Fax: 203.366.7566

_____

_____

_____

Print Facility Name, Phone Number, Fax Number and Contact Person

I, the undersigned hereby authorize the release of my Medical Records to Integrated Medical Centers in order to help in my diagnosis and / or treatment.

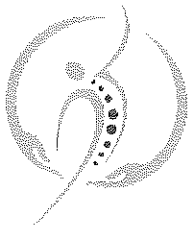
I understand that Integrated Medical Centers will protect my privacy in accordance with the government's rules and regulations stated in their Notice of Privacy Act which is available upon my request.

_____ _____

Print Patient Name Date

_____

Patient Signature



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Fairfield, CT 06825
203.333.7788
Fax: 203.336.7566

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

527 Tunxis Hill Road
Fairfield, CT 06825
Phone: 203.333.7788
Fax: 203.366.7566

Insurance Payment Agreement

Patient Name: _____

By signing below, I agree to forward **ALL** checks and payment/denial paperwork (i.e. Explanation of Benefits) to Integrated Medical Center of Fairfield. I will do so even if my insurance provider has mailed those items out to me or anyone else whose insurance I have coverage under.

If I fail to bring in the checks and paperwork, I understand that I will be held personally responsible for payment in the **FULL AMOUNT** of the services billed.

I HAVE READ THE ABOVE PARAGRAPH AND I UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

I THEREFORE AUTHORIZE INTEGRATED MEDICAL TO PROCEED WITH TREATMENT.

PATIENT'S SIGNATURE_____DATE_____

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

527 Tunxis Hill Road
Fairfield, CT 06825

Missed Appointment Policy

Any patient who fails to notify the office that they will not be able to make their appointment will be assessed a $45 missed appointment fee due on the very next visit.

By signing below I verify that I have been notified of iMed's missed appointment policy and agree to pay $45 per each occasion.

_____

Signed

_____

Print

_____

Date