VALENTE CHIROPRACTIC

Patient Registration

Name: _____ **Date:** _____
Last First Middle

Nickname or Preferred Name: _____

Sex: ☐ Male ☐ Female **Date of Birth:** ____/____/____ **Age:**_____

Address: _____

City _____ **State** _____ **Zip** _____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Driver's License # _____

I would like to be notified of my upcoming appointments by:
☐ Text Message
☐ E-mail Message
☐ No Notification Please

Contact:

Home Phone (_____)_____
Work Phone (_____)_____ EXT _____
Cell Phone (_____) _____ Carrier: _____
E-mail Address: _____

Whom may we thank for referring you? _____

Marital Status:

☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Partnered for ____ years

Spouse's name:
_____

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Preferred Language:
_____

Employment:

☐ Employed (FT)
☐ Employed (PT)
☐ Self-Employed
☐ Unemployed
☐ Homemaker
☐ Active Military
☐ Retired
☐ Disabled
☐ N/A
☐ Full-time Student
☐ Part-time Student
☐ Not a Student

Employer: _____

Occupation: _____

School: _____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship _____
Home # (____)_____ Cell # (____)_____ Work # (____)_____

Accident/Injury Information

Is your condition due to an Auto Accident? ☐ No ☐ Yes Date: _____
Is your condition due to an injury sustained at Work? ☐ No ☐ Yes Date: _____
Is your condition due to another form of accident? ☐ No ☐ Yes Date: _____

If YES please explain: _____

To whom have you made a report of your accident?
☐ L&I ☐ Worker Comp ☐ Employer
☐ Auto Insurance ☐ Other

Attorney Name (if applicable):
_____

VALENTE CHIROPRACTIC

Patient Current Condition and Pain Form

Name _____ **Date** _____

Complaint/Pain Location(s) (example: neck, upper back, mid-back, low-back, hips, extremities):

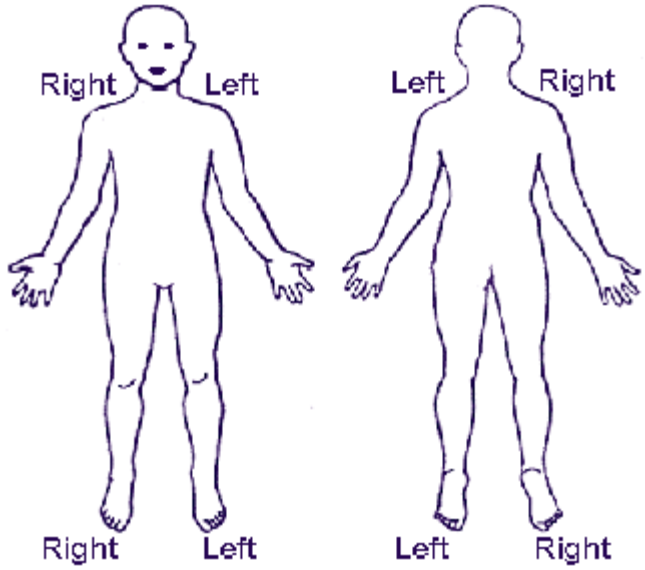
_____

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain



Front Back

On the image please indicate where you are experiencing your symptoms.

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other _____

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)
☐ Intermittently (0%-25% of the time)

When do you experience your symptoms?

Ex: every day, most days, some days, a few times a year

_____

Does your condition interfere with your.... (please check any that apply)

☐ Sleep ☐ Work ☐ Daily routine ☐ Recreational activities

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Other _____	☐	☐	☐

Additional information / Any recent falls and/or injuries / Prior condition related medical history

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VALENTE CHIROPRACTIC

Health History:

It will be assumed that any space left blank indicates that you have NOT had that test, exam, illness, disease, surgery, ect.

A. Date of last:

Physical Exam:	**Medical Doctor:**	**Bone Scan:**	**CT-Scan:**
Chiropractic:	**Chiropractor:**	**Spinal X-Ray:**	**MRI:**
Physical Therapy:	**Physical Therapist:**	**Chest X-Ray:**	**Blood Test:**
Massage Therapy:	**Massage Therapist:**	**Dental X-Ray:**	**Other:**

B. Injuries, traumas, allergies, and illnesses:

Broken Bones/Fractures: _____ Head Injuries: _____

Dislocations: _____ Falls: _____

Please check the box to indicate if you have or have had any of the following:

☐ **AID/HIV**	☐ Breast Lump	☐ Epilepsy	☐ Herpes	☐ Mumps	☐ Psychiatric Care	☐ Tuberculosis
☐ Alcoholism	☐ Bronchitis	☐ Glaucoma	☐ High Blood Pressure	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Tumors, Growths
☐ Allergy shots	☐ Bulimia	☐ Goiter	☐ High Cholesterol	☐ Pacemaker	☐ Rheumatic Fever	☐ Typhoid Fever
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Kidney Disease	☐ Parkinson's Disease	☐ Scarlet Fever	☐ Ulcers
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Liver Disease	☐ Pinched Nerve	☐ STD(s)	☐ Vaginal Infections
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Measles	☐ Pneumonia	☐ Stroke	☐ Whooping Cough
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Migraine Headaches	☐ Polio	☐ Suicide Attempt	☐
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Prostate Problem	☐ Thyroid Problems	☐
☐ Bleeding Disorders	☐ Emphysema	☐ Herniated Disk	☐ Multiple Sclerosis	☐ Prosthesis	☐ Tonsillitis	☐

Other illness or injury: _____

Allergies (ex: seasonal, peanuts) &/or Medication Allergies (ex: Penicillin, NSAID):

_____ ☐ **NO Known Allergies**

_____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ **NO Current Medications**			

E. Females- Pregnancies and outcomes:

Are you currently pregnant? ☐ No ☐ Yes **Due Date** : _____

Prior pregnancies, dates of delivery, and outcomes: _____

VALENTE
CHIROPRACTIC

2. What previous care/treatment have you received for your condition?

☐ Physical therapy ☐ Chiropractic care ☐ Medication ☐ Surgery ☐ None ☐ Other: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

3. Family Health History:

Associated health problems of relatives _____

_____

_____

4. Social and Occupational History:

A. Level of Education:

☐ High school ☐ Some college ☐ College graduate ☐ Post graduate studies
☐ Currently attending _____

B. Job description, work schedule, and work activity (eg: sitting, standing, light/heavy labor):

_____

_____

C. Habits:

Do you smoke or use tobacco products?
☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker
☐ Other: _____

Do you consume alcohol? ☐ Yes ☐ No
Amount:_____

Do you consume coffee or other caffeinated drinks? ☐ Yes ☐ No
Amount:_____

Are you under a lot of stress? ☐ Yes ☐ No
Reason:_____

D. Recreational activities:

_____

_____

F. Exercise:

Type(s):_____
(e.g: walking, running, aerobic activities, yoga, rock climbing, pool activities, softball, core training, weight lifting)

Frequency:_____
(e.g: 3 times a week, daily, twice daily, rarely, never)

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Valente/Valente Chiropractic to provide me with chiropractic care, in accordance with Washington state's statutes.

Signature _____ Date _____

Printed Name: _____

Doctor's Signature _____ Date _____

VALENTE
Chiropractic & Massage

Consent to Treatment

- I voluntarily consent to *receive* medical and health care services that may include diagnostic procedures, examination and treatment.
- As with all health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravation and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies such as heat and ice packs, fractures, disc injures. strokes, sprains, strains, and dislocations. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with potential to lead to a stroke.
- I agree with the current or future recommendation to receive chiropractic care, massage therapy, and manual therapy as it is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care, massage therapy, or manual care from this office.

Assignment of Benefits

- I hereby assign, transfer, and set over to Valente Chiropractic PLLC all of my rights, title, and interest to *my* medical reimbursement benefits under my insurance policy.
- Valente Chiropractic may use my health care information and may disclose such information and insurance companies involved in *my* treatment for the purposes of obtaining payment for services, determining insurance benefits, and/ or determining benefits payable for related services.
- I understand that Valente Chiropractic PLLC may file a UCC lien in order to obtain direct payment from my associated insurance companies. The lien may include my name, address, claim number, monies owed, an insurance company's name and address, and this form. Copies of the UCC lien can be obtained from the Washington State Department of Licensing UCC Search.
  I understand that should I open a claim, change insurances, or should my insurances coverage change that it may be necessary to sign a new assignment and release form.

Financial Responsibility

- I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I understand a quote of benefits by Valente Chiropractic does not guarantee payment by *my* insurance company or guarantee benefit eligibility.
- A copy of our full financial policy and standard fee schedule is available to any patient, insurance company or third party.

Release of Information

- I hereby authorize the release of medical information necessary to process my charges or insurance claims. This may include intake forms, chart notes, reports, correspondences, billing statements and other information to my attorney(s), health care provider(s), insurance compan(ies) and case manager(s).

Massage Therapy Agreement

Updated: Effective February 1st, 2023

- **I understand that I will be charged and agree to pay a $50 cancellation fee if I do not show up for my massage appointment or do not cancel within 24 hours notice.**
- **I understand that I will be charged and agree to pay a $70 cancellation fee if I do not show up or late cancel over 3 massage appointments.**
- **I understand that I will be charged and agree to pay a $12.50 late fee if I am more than 15 minutes late to my appointment.**

Signature:_____**Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Valente Chiropractic
Effective Date: February 9, 2012

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

☐ **Spouse:** _____ □ Yes, Health Info □Yes, Billing Info □Yes, Scheduling

☐ **Parent/s or Guardian/s:** _____
□ Yes, Health Info □Yes, Billing Info □Yes, Scheduling

☐ **Relative/Friend/Other:** _____ **Indicate Relationship:** _____
□ Yes, Health Information □Yes, Billing Information □Yes, Appointment Scheduling

Acknowledgment of Receipt of this Notice As a patient of Valente Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Valente Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have health insurance coverage with_____
Insurance Carrier

Patient Name:_____ Subscriber Name:_____
Member ID:_____ Subscriber Birthdate:_____
Group No:_____ Subscriber Relation:_____

OR

have a claim open with or wish to open/re-open a claim with:

1st Party Auto (Your Auto Insurance) 3rd Party Auto (Other Party's Ins) Workers' Comp / L&I

_____ _____ _____

Claim #_____ Claim #_____ Claim #_____

☐ I have PIP/Med Pay on my policy (**Please call your Auto Insurance if you are not sure**)

☐ By checking this box I am requesting **not to bill my health insurance** at this time. I am aware I will be responsible for all incurred charges until I sign a new assignment and release stating otherwise.

Signature:_____