



Dr. Sara Young, D.C.  
510 W Savidge St. Ste. E  
Spring Lake, MI 49456  
Phone: (616) 850-0588

**REGISTRATION & HISTORY**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Sex: M F Age: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_\_\_ Status: \_\_Single \_\_Married \_\_Separated \_\_Divorced  
 Patient Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Employer Phone:(\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_  
 Primary Care Provider: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

PHONE NUMBERS	EMERGENCY CONTACT
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<p>Home: _____          Work: _____          Cell: _____          Preferred Contact: __Home __Work __Cell          Email: _____</p>	<p>Name: _____          Relationship: _____          Home: _____          Work: _____          Cell: _____</p>
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**PRIMARY INSURANCE INFORMATION**

Person Responsible for Account: \_\_\_\_\_  
 Relation to Patient: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
 Address **if different from patient**: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Person Responsible Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Work Email: \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone: \_\_\_\_\_  
 Contract #: \_\_\_\_\_ Group#: \_\_\_\_\_  
 Name of other Dependents under this plan: \_\_\_\_\_

# PATIENT INFORMATION

Reason for Visit: \_\_\_\_\_

When did it start?: \_\_\_\_\_ How? \_\_\_\_\_

Was this injury related to an accident?:  Yes  No If yes, was it:  Work  Auto  Other \_\_\_\_\_

Please describe your condition: \_\_\_\_\_

Rate your symptoms (0=Best, 10=Worst): \_\_\_\_/10 With time is your condition:  getting better  getting worse  no change

Are your symptoms constant or do they come & go?:  Constant  Come & Go

What makes the symptoms worse?  Standing  Sitting  Walking  Bending/lifting  Lying down  Exercise  Self-care

What makes your symptoms better? \_\_\_\_\_

What treatments have you already had for this condition:  none  Medical  Chiropractic  Surgical  Physical Therapy  
 Acupuncture  Other (please describe) \_\_\_\_\_ Last time seen: \_\_\_\_\_

Have you had any recent imaging of the area?  X-Ray  MRI  CT Scan  Bone Density/DEXA  Other

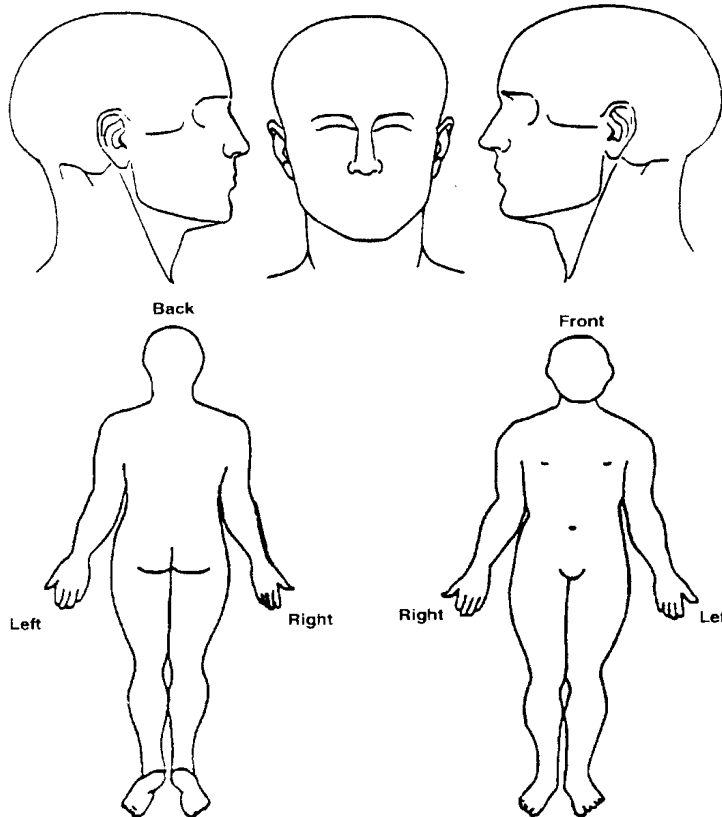
Does your condition interfere with your activities (work duties, daily life, social activities, recreation)?  Yes  No

If Yes, please list 3 Activities you have difficulty with:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Mark the location of your symptoms with the labels below

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^	===	ooo	.....	////	xxx
^^^	===	ooo	.....	////	xxx



**HEAD / NECK**

No Pain ←————→ Worst Pain

Draw a slash on the lines as to the level of your pain in those areas

No Pain ←————→ Worst Pain

**BODY**

HEALTH HISTORY										
<b>Have you had any of the following:</b>			Herniated Disk	Y	N	Numbness	Y	N		
AIDS/HIV	Y	N	High Blood Pressure	Y	N	Where? _____				
Anemia	Y	N	High Cholesterol	Y	N	Tingling	Y	N		
Anxiety	Y	N	Jaw Pain	Y	N	Where? _____				
Arm/Shoulder Pain	Y	N	Leg Pain	Y	N	Muscle Spasms	Y	N		
Arthritis	Y	N	Multiple Sclerosis	Y	N	Where? _____				
Asthma	Y	N	Osteopenia	Y	N	<b>WOMEN ONLY:</b>				
Bleeding Disorders	Y	N	Osteoporosis	Y	N	Are you Pregnant?	Y	N		
Cancer	Y	N	Pacemaker	Y	N	Due Date: _____				
Chemical Dependency	Y	N	Parkinson's Disease	Y	N	Abnormal/Painful	Y	N		
Depression	Y	N	Pinched Nerve	Y	N	Menstrual Cycle	Y	N		
Diabetes	Y	N	Polio	Y	N	Miscarriage	Y	N		
Ear Aches (severe)	Y	N	Prostate Problem	Y	N	Menopause	Y	N		
Epilepsy/Seizures	Y	N	Prosthesis	Y	N	<b>PRIOR SURGERY/HOSPITALIZATION</b>				
Fractures	Y	N	Psychiatric Care	Y	N	DATE	REASON			
Frequent Headaches	Y	N	Rheumatoid Arthritis	Y	N	_____	_____			
Frequent Low Back Pain	Y	N	Sinus Trouble	Y	N	_____	_____			
Frequent Mid Back Pain	Y	N	Stroke	Y	N	_____	_____			
Frequent Neck Pain	Y	N	Suicide Attempt	Y	N	_____	_____			
Heart Disease	Y	N	Thyroid Problems	Y	N	_____	_____			
Hepatitis	Y	N	Tumors	Y	N	_____	_____			
Hernia	Y	N	Ulcers	Y	N	_____	_____			

MEDICATIONS	ALLERGIES	VITAMINS / SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY (Does anyone in your family have the following?)								
Arthritis / Rheumatism	Y	N	Diabetes	Y	N	Osteoporosis/Osteopenia	Y	N
Autoimmune Disorders	Y	N	Heart Disease	Y	N	Stroke	Y	N
Back/spine Condition	Y	N	High Blood Pressure	Y	N	Thyroid Disorder	Y	N
Cancer	Y	N	Mental Illness	Y	N	Who? _____		

SOCIAL HISTORY		
My Work Duties Include: ___ Standing ___ Sitting ___ Light Labor ___ Heavy Labor ___ Other		
My Exercise Level is: ___ Intense ___ Moderate ___ Light ___ Minimal ___ None		
My Current Exercise Includes: (list activities) _____		
My Habits Include: ___ Smoking/Tobacco Use of	___ Alcohol Consumption	___ Caffeine (coffee, soda, tea)
~ ___ packs per day	~ ___ drinks per week	~ ___ cups per day
___ High Stress Level	___ Recreational Drug Use	

AREAS OF INTEREST		
<input type="checkbox"/> Herbal Supplements	<input type="checkbox"/> Weight Loss Information	<input type="checkbox"/> Ear Infection / Colic / ADD
<input type="checkbox"/> Nutritional Supplements	<input type="checkbox"/> Women's Health	<input type="checkbox"/> Pregnancy Care
<input type="checkbox"/> Detoxification	<input type="checkbox"/> Neck/Body Pillows	<input type="checkbox"/> Children's Care
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migun Massage Bed	<input type="checkbox"/> Other _____
<input type="checkbox"/> Exercise Instruction	<input type="checkbox"/> Nutrition	_____
<input type="checkbox"/> Massage	<input type="checkbox"/> Wellness Care	_____

**Authorization & Assignment**

I authorize Lakeshore Family Chiropractic to release and information deemed appropriate concerning my physical condition to any Insurance Company, Attorney or Adjuster in order to process any claim for reimbursement of chargers incurred by me.

I authorize direct payment to you of any sum I now or hereafter owe you by my Attorney out of the proceeds of any settlement of my case, and by any Insurance Company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Lakeshore family Chiropractic authority necessary to endorse and cash my checks, drafts or money order which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned in the clinic.

I understand and agree that health and accident insurance policies are an agreement between an Insurance Carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court cost required to collect my bill.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**Authorization & Assignment**

I Understand and am informed that, as in all health care, in the practice of chiropractic there is a small risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my Doctor will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in orthopedic, neurological and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my Doctor.

\_\_\_\_\_ PRINTED PATIENT NAME \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

**CONSENT OF TREATMENT OF A CHILD:**

I hereby authorize Dr. \_\_\_\_\_ and whomever he/she may designate as assistance to administer Chiropractic care as he/she deems necessary to my \_\_\_\_\_ (indicate relationship to child).

Name of child: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Signature of Staff: \_\_\_\_\_

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## WELCOME TO LAKESHORE FAMILY CHIROPRACTIC HEALTH & WELLNESS

We are excited to take care of all your health care needs, but first, it is important that you know our current office policies (effective 08/15/10). If you are a returning patient, be advised, some of these policies may have changed since your last visit. Please don't hesitate to ask us if you have any questions.

PLEASE READ AND INITIAL AFTER EACH SECTION:

### BILLING INSURANCE

Lakeshore Family Chiropractic Health & Wellness is a preferred provider for many, but not all insurance companies. As a courtesy, we will bill your *primary insurance*. Please present a current insurance card or proof of insurance with ID. Although we try to verify your coverage's for services, *we cannot guarantee that your insurance will pay*. We are not insurance agents. We can only estimate your portion of the bill at time of service. If your insurance company denies your claim, or pays less than expected, you will be billed for the balance. You are responsible for all charges incurred at Lakeshore Family Chiropractic Health & Wellness regardless of insurance coverage.

Initials: \_\_\_\_\_

### PAST DUE ACCOUNTS

Your estimated portion of the bill is due at the time of service. If you have insurance, we will do our best to estimate your portion; however, you may receive a statement after insurance has been processed. In efforts to keep our health care costs down, we ask that you pay promptly. Accounts over 30 days past due will incur finance fees of 10% per month until balance is paid off. Accounts over 120 days will be sent to a collection agency and may accrue addition fees. To avoid this, payment plans may be arranged and we accept most major credit cards.

Initials: \_\_\_\_\_

### HIPAA

In accordance with Health Insurance Portability & Accountability Act (HIPAA), Lakeshore Family Chiropractic Health & Wellness will treat your medical records and personal information with the most respect and privacy. Please see our Notice of Privacy Practices; you may request a copy for your records at any time.

Initials: \_\_\_\_\_

### RED FLAG RULE

In accordance with the Federal Trade Commission, we must see a current driver's license / ID card to verify identity (patients over 18). This is mandatory for any patients who want their insurance billed. This is an effort to reduce credit card fraud, insurance fraud, and identify theft issues. Patients refusing to provide ID must pay cost at the time of service.

Initials: \_\_\_\_\_

## SIGNATURE ON FILE

Your personal and medical health information will be used to provide quality chiropractic care; including diagnosis, and treatment and proper referrals when appropriate. This information may also be used by Lakeshore Family Chiropractic Health & Wellness to bill insurance, collect payments, and make medical referrals as needed.

Initials: \_\_\_\_\_

## TRANSFER OF RECORDS

You must sign an official *release of records* if you wish for any of your information (medical or personal) to be shared with anyone outside of Lakeshore Family Chiropractic Health & Wellness. Likewise, if you would like us to assist in getting copies of your records from past doctors, please ask the receptionist for a *request of records* form that makes it easy.

Initials: \_\_\_\_\_

## MISSED APPOINTMENTS

We understand that uncontrolled circumstances and emergencies happen. We do not have a missed or canceled appointment fee. We just request that you give us a call so we can fill your adjustment if another Practice Member requests it.

Initials: \_\_\_\_\_

## PLEASE READ, SIGN & DATE BELOW

In signing below, I state that I understand and accept Lakeshore Family Chiropractic Health & Wellness' Policies. In addition, I authorize Lakeshore Family Chiropractic Health & Wellness to release any information required to process insurance claims and authorize insurance payment to be paid directly to Lakeshore Family Chiropractic Health & Wellness. I understand that my insurance company may pay less than the actual bill for services. I the Patient/Responsible Party, accept financial responsibility for all charges incurred regardless of insurance coverage.

PRINT Patient's Name: \_\_\_\_\_

PRINT Name of Responsible Party (if not Patient): \_\_\_\_\_

SIGNATURE of Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_



LIVE HEALTHY  
LIVE NATURAL  
LIVE HAPPY