ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and received a copy for my records from:

Advanced Chiropractic & Rehab
4 Corporate Drive, Suite 385
Shelton, CT 06484
203-929-5500

Name (please print) : _____ Date of Birth: _____

Signature: _____Today's Date:_____

8.2-MTBC-F-07

A Unique Healthcare IT Company®

CONFIDENTIAL

ADVANCED MEDICAL & REHAB

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient

◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ___/___/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (___) _____-_____

CELL PHONE: (___) _____-_____

PATIENT'S NAME: _____ , _____ _____

LAST *FIRST* *MI*

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SSN: _____ - _____ - _____ **SEX:** ◯ *M* ◯ *F* **BIRTH-DATE:** ___/___/_____ ◯ *SINGLE* ◯ *MARRIED* ◯ *DIVORCED* ◯ *SEPARATED* ◯ *WIDOWED*

Patient Employed By : _____

Business Address: _____

Occupation: _____ **Business Phone:** (___) _____-_____

Name of Spouse/Responsible Party (If Patient is minor): _____ , _____ _____

LAST *FIRST* *MI*

Spouse/Responsible Party Employed by: _____

Business Address: _____

Occupation: _____ **Business Phone:** (___) _____-_____

RESPONSIBLE PARTY/SPOUSE SSN : _____ - _____ - _____

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : _____ **ID #:** _____ **GRP #:** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

ADDRESS OF PRI. INS. : _____

NAME OF SEC. INS. : _____ **ID #:** _____ ***GRP #:*** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

ADDRESS OF SEC. INS. : _____

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PIH _____ Relationship _____

PHONE: (___) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to

(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____

(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

_____ _____

(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

CONFIDENTIAL PATIENT CASE HISTORY — HEALTH INFORMATION

Name: _____

What is your major complaint? _____

How did this problem begin (e.g. fall, lifting, etc.)? _____
How long have you had this condition? _____ have you had this or similar conditions in the past? _____
What activities aggravate your conditions? _____
What relieves your condition? _____
Other doctors who treated this condition? _____
How long has it been since you really felt good? _____
Other complaints: _____
List surgical operations and years: _____

Drugs you now take: ○ Nerve pills ○ Muscle relaxers ○ Pain Killers ○ Pop pills ○ Insulin
○ Tranquilizers ○ Birth control pills ○ others _____

Vitamins Supplements you now take: _____

Sleeping position: ○ Back ○ side ○ stomach Do you wear: ○ heal lifts ○ Arch supports

Have you ever been in a motor vehicle accident? ○ No ○ Yes When? _____

Were you injured? ○ No ○ Yes (describe): _____

Have you had any other personal injury or accident? ○ No ○ Yes When? _____
Describe: _____

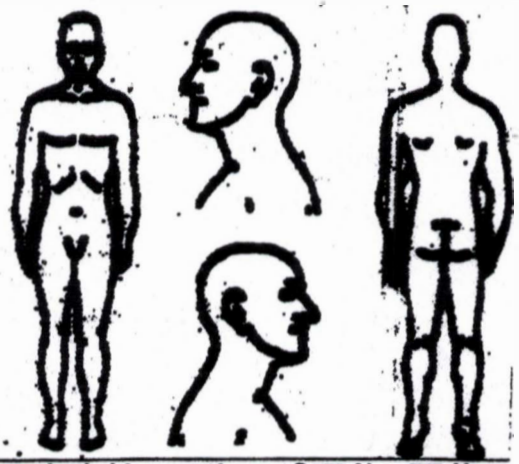
Is there a family history of: ○ Heart Disease ○ Cancer ○ Stroke Describe: _____

Do you have any children? ○ No ○ Yes (Ages): _____

Date of last physical examination: _____

Do you exercise? ○ No ○ Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURE BELOW



Have you ever had chiropractic care? ☐ No ☐ Yes

When? _____ Why? _____
Where _____
Were X-rays taken? ☐ No ☐ Yes

Have you in the past or do you presently suffer from any of the following:

- ☐ Dizziness
- ☐ Heat Trouble
- ☐ Arthritis
- ☐ Neuritis
- ☐ Nervousness
- ☐ Neck Pain
- ☐ Painful Menstrual Cycle
- ☐ Headaches
- ☐ Backaches
- ☐ Diabetes
- ☐ Asthma
- ☐ Digestive Disorders
- ☐ Sinus Trouble
- ☐ High Blood Pressure
- ☐ Cancer

Present reasons for consulting the office:

- ☐ Improving self and or/family health
- ☐ maximizing personal health
- ☐ Preventing disease and/or symptoms