ISLAND OASIS CHIROPRACTIC

Patient Registration

Welcome! Please print.

Patient Name _____ Date of birth _____ Age_____ Ht._____

Address _____ Apt# _____City _____ State _____ Zip _____

Home#_____ Mobile # _____ Work# _____

Can we text you appointment reminders/specials? _____Yes _____No Cell Carrier_____

Email Address _____

Can we email you appointment reminders/specials/monthly newsletters? _____Yes _____No

Relationship Status: Single / Married / Divorced / Widowed Number of children_____

Employment Status: Full time / Part time /Retired / Unemployed/ Student /Other_____

Your Employer_____ Your Occupation_____

Employer Address_____City_____State_____ Zip _____

Do you have health insurance where you work? _____Yes _____ No Social Security #_____

Name of Insurance Company_____ Plan/Group _____

Name of spouse _____ Occupation _____Phone # _____

Spouse's Employer _____

Address _____City _____State_____ Zip _____

Does your spouse have health insurance at work? _____Yes _____No

Name of Insurance Company_____ Plan/Group _____

Emergency Contact _____ Relation _____ Phone # _____

How did you hear about our office? _____

Is your condition due to an auto accident? _____Yes _____No Date of accident_____

I agree to pay for all services rendered to the above named patient as the charge is incurred. I understand that health and accident insurance policies are arrangements between an insurance carrier and me and that I am personally responsible for any and all services, covered or not covered. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THIS OFFICE. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I understand and agree:

Patient Signature (Parent or Guardian) _____ Date _____

ISLAND OASIS CHIROPRACTIC

CASE HISTORY Page 1

Patient Name_____ Date: _____

Symptom Description

Describe Your Major Complaint_____

_____

_____

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN
0	1 2 3	4 5 6 7	8 9 10

Describe your complaint: (Please circle all appropriate)

sharp- -dull- -stabbing- -aching- -radiating- -burning- -throbbing- numbness- -tingling- -stiff-

When did this condition begin? Date_____

Is your complaint? Constant- -Frequent- - Intermittent- -Occasional

What caused your complaint? _____

Since Onset Have your symptoms:

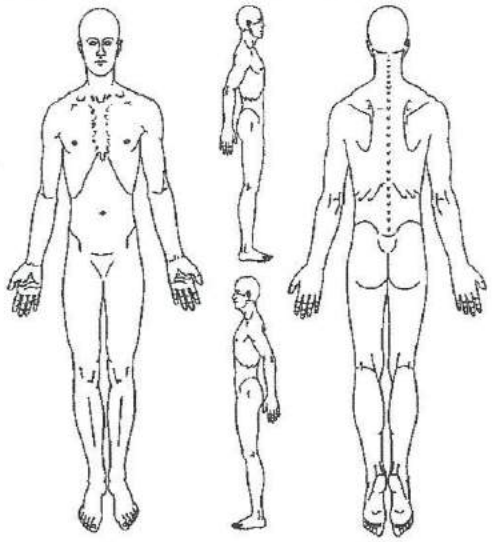
◯ Decreased ◯ Increased ◯ Remained the Same ◯ Erratic

Changes in Activities of Daily Living: ◯ YES ◯ NO

◯ Forgotten with activity ◯ Interferes with activity ◯ Prevents activity
◯ Activity continues despite problem

Please CODE or SHADE area(s) to indicate location of pain or discomfort.

A = ACHE **B** = BURNING
S = SHARP **N** = NUMBNESS
F = STIFF **T** = TINGLING



Other Symptoms

__Headache
__Neck Pain
__Neck Stiffness
__Shoulder Pain
__Upper Back Pain
__Mid Back Pain
__Low Back Pain
__Low Back Stiffness
__Hip Pain
__Arm/Hand Pain
__Leg/Foot Pain
__Numbness Arm/Hand
__Numbness Leg/Foot
__Tingling Arm/Hand
__Tingling Leg/Foot
__Chest pain

What makes your condition Better/Worse? (Please circle all appropriate)
Worse With: Sitting- -Standing- -Lying Down- -Movement- -Rest- -Walking- -Running- -Work- -Normal Daily Activities
Better With: Sitting- -Standing- -Lying Down- -Movement- -Rest- -Walking- -Running- -Work- -Normal Daily Activities

When is your condition Better/Worse? (Please circle all appropriate)
Worse: Morning- -Evening- -Afternoon- -While Sleeping- -During Menstrual Period- -After Work or Extensive Activity
Better: Morning- -Evening- -Afternoon- -While Sleeping- -During Menstrual Period- -After Work or Extensive Activity

Past History

__None - I have never had this condition before now.
__Similar Symptoms - When _____ Past Treatment: Manipulation- -Medication- -Surgery- -PT- -Other _____
__ Same Symptoms - When _____ Past Treatment: Manipulation- -Medication- -Surgery- -PT- -Other _____

Past Diagnostic Workup

__No Past Diagnostic Workup
__ Past procedures performed for this condition: (Please circle all appropriate)
X-Ray- -MRI- -CAT Scan- -NCV- -Bone Scan- -Blood Work- -Urine Test- -EMG- -Diagnostic Ultrasound- -Doppler Study
Other_____

Exercise? Yes- -No, If yes (circle appropriate) Occasionally- -Frequently- -Regularly
Tobacco? Yes- -No, If yes (circle appropriate) Cigarettes- -Cigars- -Pipe- -Chewing Tobacco- -Snuff- -
Various Types Alcohol? Yes- -No, If yes (circle appropriate) Socially- -Occasionally- - Frequently- -Regularly
Caffeine? Yes- -No _____Cups/Ounces per day **Handedness:** ☐ Right ☐ Left

Do we have your permission to send a report/records to your primary care physician and/or specialist? Yes- -No

ISLAND OASIS CHIROPRACTIC

CASE HISTORY Page 2

Past Treatment: For current complaint(s) (please check mark AND circle appropriate)

__ No Past Treatment

__Manipulation/Adjustment:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Anti-Inflammatories:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Muscle Relaxers:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Pain Medication:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Physical Therapy:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Surgery:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Exercise:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Bed Rest:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Ice/Heat:	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Other_____	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief
__Other_____	Complete Relief- -Significant Relief - -Marginal Relief- -No Significant Relief

Past Doctors

Name_____, Approximate Date ____/____/_____ Type Visit: Treatment- -Consultation

Type Doctor: Chiropractor- -Primary Care- -Neurosurgeon- -Neurologist- -Orthopedic- -Physical Medicine

Name_____, Approximate Date ____/____/_____ Type Visit: Treatment- -Consultation

Type Doctor: Chiropractor- -Primary Care- -Neurosurgeon- -Neurologist- -Orthopedic- -Physical Medicine

Review of Systems List any health problems you currently have.

__Cancer	__Hypertension	__Heart	__Lung	__Gastrointestinal
__Kidney	__Liver	__Gall Bladder	__Thyroid	__Diabetes Mellitus
__Uterine	__Prostate	__Neurological	__Allergies	__Asthma
__Osteoporosis	__Osteoarthritis	__RA	__HIV	__AIDS

Family History (circle appropriate)

Respiratory Disease:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Hypertension:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
GI/GU Disease	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Diabetes Mellitus:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Skin Disease:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Neurologic Disease:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Arthritic Disease:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Stroke:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Heart Disease:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Cancer:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather
Death in Family:	Mother- -Father- -Brother- -Sister- -Maternal Grandmother / Grandfather - - Paternal Grandmother / Grandfather

Please list all past surgeries if any:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Please list all previous auto accidents, accidents and falls (even if sought NO treatments for it):

What _____ When _____

What _____ When _____

What _____ When _____

Are you taking Coumadin, Heparin or other blood thinners? ___Yes ___No

List Current Medications (Name of medication and reason you are taking it)

_____

_____

_____

By signing below, I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health or condition.

_____ _____

Patient Signature Date

ISLAND OASIS CHIROPRACTIC

Patient Health History

Patient Name: _____ Date: _____

Present	Past		Present	Past	
		Fainting			Aortic Aneurysm
		Visual Disturbances			Angina
		Convulsions			Heart Attack (date)
		Dizziness			Stroke (date)
		Headaches			Tumor, Explain
		Muscular In coordination			Ulcer
		Tinnitus (Ear Noises)			Kidney Stones
		Rapid Heart Beat			Hepatitis
		Chest Pain			Bladder Infection
		Loss of Appetite			Blood in urine or stool
		Abnormal Weight ☐ Gain ☐ Loss			Hardening of the arteries
		Chronic Cough			Carotid artery surgery
		Chronic Sinusitis			Bulging disc
		General Fatigue			Herniated disc
		Loss of Bladder/Bowel Control			Spinal Surgery (date)
		Painful/Difficult Urination			Partial or complete paralysis
		Abdominal Pain			Neck Pain
		Constipation/irregular bowel habits			Shoulder Pain (R___L___)
		Difficulty in Swallowing			Pain in Upper Arm/Elbow (R__L__)
		Heartburn/Indigestion			Hand Pain (R___L___)
		Dermatitis/Eczema/Rash			Wrist Pain (R___L___)
		Depression			Upper Back Pain
		Epilepsy			Low Back Pain
		Blood Disorder			Pain in Upper Leg or Hip (R__L__)
		Claustrophobia			Pain in Lower Leg or Knee (R__L__)
		Nausea			Jaw pain
		Vomiting			Swelling, Stiffness of joints
		Numbness or other sensory complaints			Difficulty walking
		Loss of consciousness			Incoordination
		Memory Loss			A minor fall
		Clumsiness			A major fall
		Speech Problems			Fractured vertebrae
		Head Trauma			Fractured bone (other than vertebrae)
		Fever			Work Injury
		Loss of Strength (weakness)			Hormone therapy ☐ Male ☐ Female
		Women ONLY			
		Irregular Menstrual periods			Breast removal / augmentation
		Profuse Flow			Endometriosis
		PMS			Taking Birth Control
		Pregnant (___# of weeks)			Hysterectomy ☐ Tubal Ligation ☐

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes to my health history.

_____ _____

Patient Signature Date

ISLAND OASIS CHIROPRACTIC

Patient Health Information Consent Form (HIPAA)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Name _____

Signature of Patient _____ Date _____

INFORMED CONSENT FOR TREATMENT

Island Oasis Chiropractic, P.L.L.C.
Christina Cochran, D.C.
620 Village Drive
Virginia Beach, V.A. 23454
757-333-0368

The nature of the Chiropractic treatment. The primary treatment used at Island Oasis Chiropractic, P.L.L.C is the spinal adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation and/or joint misalignments. Our chiropractic method of correction is by specific adjustments of the spine or joints in the body. Adjustments are usually done by hand but may be performed by handheld instruments. That may cause you to hear a "pop" or "click" much as you might have experienced when you "crack" your knuckles. You may feel or sense movement. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or cryotherapy may also be used.

The material risks inherent in Chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

The probability of those risks occurring.
The risk of complications due to chiropractic treatment have been described as "rare" , about as often as complications are seen from the taking of a single aspirin tablet. Any type of complication is very rare and generally results from some underlying weakness of the bone, which we check for during the taking of your history and during the examination. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The probability of adverse reaction due to ancillary procedures is also considered "rare".

The risk and dangers of remaining untreated. Remaining untreated allows the formation of adhesions, scar tissue, degenerative changes, and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

The availability and nature of other treatment options not supplied through our office.
Other treatment options for your condition may include:

- Self-administered, over-the- counter analgesics and rest
- Medical care with prescriptions drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

The material risks inherent in such options and the probability of such risks occurring include:

- Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance and self discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

- Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance and self discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is uncertain, and exposure to communicable disease is likely with adverse result from such exposure upon unknown variables

- The risk inherent in surgery is dependent on the type of surgery and include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and extended convalescent period. The probability of those risks occurring varies according to the many factors.

***DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.**

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Dr. Christina Cochran and her staff to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

Patient Printed Name	**Signature of Patient**
Printed Name Of Minor	**Signature of Parent or Or Guardian (If a Minor)**
Signature of Doctor	**Date**

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa. We do offer a prompt pay discount of 25% if you pay all visits at the time of service.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our prompt pay discount in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay or PIP portion of your auto insurance.
3. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEX PLANS/HEALTH SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the financial policy of Island Oasis Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Island Oasis Chiropractic and my insurance company. I request that Island Oasis Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, if I suspend or terminate my schedule of care as prescribed by the doctor at Island Oasis Chiropractic that fees will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

Pregnancy History

Patient Name: _____ Date: _____

# of pregnancies: _____ # of children born alive: _____

# of miscarriages: _____ # of stillbirths: _____ # of abortions: _____

If you had any miscarriages, how far along were you?

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Have you ever had any blood transfusions? _____

Have you ever taken a fertility drug of any kind? _____ Which? _____

Have any of your children had birth defects of any kind? Describe fully:

_____

_____

Have you ever had any pregnancy or labor complications? Describe fully:

_____

_____

Have any of your babies received blood transfusions within two weeks of their birth? Describe fully:

_____

_____

Have you ever delivered any babies more than two weeks before your due date? _____

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Name of OB Doctor: _____ Did this physician refer you to our office? _____ Y/N

Summary of All Previous Pregnancies:

#	Year	Place of Confinement	#Weeks Pregnant	Duration of Labor	Weight	Gender	Name

_____ _____

Patient Signature Date