MONTVILLE
CHIROPRACTIC

9 Maple Avenue Ext.
Uncasville, CT 06382
Phone: 860-848-8977
montvillechiropractic@outlook.com

Dr. Michael Murphy

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name _____ MI _____ First Name _____

Date of Birth _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address if different_____
Street *City* *State* *Zip*

Home Phone _____ Work Phone _____ Other/Cell Phone _____

EHR Certification – Patient Information

Gender: ☐ Male ☐ Female	**Student Status:** ☐ Full time student ☐ Part time student ☐ Not a student	**Are you a veteran?** ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner ☐ Other:_____	**Smoking Status?** ☐ Smoke Everyday ☐ Smoke Occasionally ☐ Former Smoker ☐ Never Smoked	**Primary Language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other:_____
Race: ☐ White ☐ Black / African-American ☐ Asian ☐ American Indian / Alaskan Native ☐ Hispanic/Latino ☐ More than one race ☐ Other: _____		
OFFICE USE ONLY **Blood Pressure** _____/_____ **Height:** _____ **Weight**_____		

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List Prescribed Medications □ Check box if you are not taking any medication	**# of MD Refills issued**	**Quantity & Strength**	**Dose Form** **(i.e. capsule)**	**MD's Instruction** **(i.e. 1 per day)**

Are you Allergic to any Medicines? (please list)

□ Check box if you have No Medical Allergies

Describe Allergic Symptom: (i.e. headache)

Have you been diagnosed with either of the following? (Please Circle)
Asthma? Diabetes?

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What is your preferred method of contact? □ **Phone Call** □ **Text Message** □ **Email**

Phone (provide number) _____ (circle) Home Work Cell

Secondary Number_____(circle) Home Work Cell

Text Message (provide number) _____**Carrier** (Verizon, AT&T etc.):_____

E-Mail (provide address)_____

Would you like to receive Automated Reminders of appointments and office events?
□ Email reminder □ Text reminder □ No Automation - Please call directly

Would you like to receive our complimentary Newsletter?
□ Yes - send via Email □ Yes- mail to my home address □ No I prefer not to receive

Please tell us how you heard about Dr. Murphy/Montville Chiropractic
□ Health Professional □ Friend □ Family Member □ Radio □ Advertisement □ Event
Name/Other_____

Responsible person: (if different from patient)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address_____
Street *City* *State* *Zip*

Relationship to patient_____

Person to contact in case of emergency:

Name _____ Telephone # _____

Relationship to patient _____

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Primary Care Physician_____
Name *Phone*

_____
Street Address *City* *State* *Zip*

Employer Name: _____

Employer Address: _____
Street *City* *State* *Zip*

Is your Visit Related to the Following: (Please check the appropriate box))

Auto Accident: □ **Yes** □ **No** **Workers' Compensation:** □ **Yes** □ **No** **Other Accident**: □ **Yes** □ **No**

Explain: _____

MEDICAL INSURANCE INFORMATION

Please **Indicate Primary Insurance**: BC/BS Aetna Connecticare United Healthcare Medicare Self-Pay

Other: (Name of Insurance)_____

Member ID number _____ Group # _____

Name of Subscriber _____ DOB: _____

Employer _____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) _____
Street *City* *State* *Zip*

Please **Indicate Secondary Insurance**: (Name of Insurance)_____

Member ID number _____ Group # _____

Name of Subscriber _____ DOB: _____

Employer _____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) _____
Street *City* *State* *Zip*

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I give permission to discuss my medical condition, diagnosis and financial account with:

Name: _____**Relationship:**_____ **Phone #:**_____

Name: _____**Relationship:**_____ **Phone #:**_____

ASSIGNMENT OF BENEFITS

(Please read carefully and sign and date where indicated.)

Assignment of Benefits: I hereby assign medical benefits, to which I am entitled to: Montville Chiropractic. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

INSURANCE SIGNATURE ON FILE: I request that payment of authorized insurance benefits be made to me or on my behalf to Montville Chiropractic, for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agent any information needed to determine these benefits for related services.

Patient/Guardian Signature: _____Date:_____

MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made to me or on my behalf to Montville Chiropractic, for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agent any information needed to determine these benefits for related services.

Patient/Guardian Signature: _____Date:_____

SELF-PAY (No Assignment of Benefits required): I attest that all the information I have provided on this form is correct, and that I will be paying out-of-pocket for all treatments received at Montville Chiropractic. I authorize any holder of medical information about me to release any information needed by Montville Chiropractic

Patient/Guardian Signature: _____Date:_____

PROTECTED HEALTH INFORMATION (PHI): I give permission to Montville Chiropractic to follow my instructions shown below regarding my PHI. The following PHI will remain in effect until revoked or revised by me in writing.

Confirm Appointment and/or Leave Message at: (please check preference)
□ home □ work □ cell □ text □ via person or □answering machine □other _____

☐ **I acknowledge receipt of Montville Chiropractic Notice of Privacy Practices.**

☐ **Patient declined Montville Chiropractic Notice of Privacy Practices:_____ (M.C. Initials).**

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OFFICE POLICY

We believe that clear definition of our office policies will allow you; the patient, and us, the doctor to concentrate on the big issue –

-REGAINING AND MAINTANING YOUR HEALTH-

APPOINTMENT POLICY

- Multiple appointments will be scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.
- Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts; and not the days.
- Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to prioritize your wellness and make up a missed appointment within **7 days** of any cancellation.
- This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice.
- When entering the office on any given visit, please go directly to the front desk and "sign-in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak with the receptionist directly.

FINANCIAL POLICY

- It is our office policy that all services rendered in the office are billed to your insurance company, if applicable. If for any reason your insurance company rejects your claims, you are personally responsible for all charges incurred.
- All payments, including co-pays and deductibles, are expected at the time of service.
- Returned checks and balances over 30 days may be subject to additional collection fees and applicable interest charges.
- A charge of $20 will be incurred for all appointments that are missed or those not cancelled with 24 hours notice.

Patient Name _____

Patient's Signature _____ Date: _____

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CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I (We) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____by Dr. Murphy D.C. and/or other licensed doctors of chiropractic who may be engaged in practice in the Montville Chiropractic clinic.

I have had the opportunity to discuss with Dr. Murphy D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts know then, is in my best interest.

I have also been advised that although the incidence of complication associated with chiropractic services is very low, anyone undergoing adjustment or manipulation procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below, agree to the named procedures.

_____
Patient's Name

_____
Patient's Signature

_____
Date

Witness _____

_____
Relationship or Authority if not signed by Patient

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PATIENT INFORMATION AND CONSENT FOR DRY NEEDLING AS A PROCEDURE FOR THE ASSESSMENT AND TREATMENT OF MYOFASCIAL TRIGGER POINTS AND TENDER POINTS

Myofascial trigger points and tender points which appear in soft tissue are painful sites and reflect abnormal nervous system activity associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating and monitoring changes in myofascial trigger/tender points. During this procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles may be used, and the procedure may be performed during more than one office visit. The number of needles and the frequency of the procedure will depend entirely on your condition at each office visit. There is little to no pain with this procedure. There is little to no bleeding with this procedure. While infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is the risk of infection. Other unlikely but possible events include fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example: Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example: Tylenol, Advil, Aleve, or Bufferin), **please Inform us by placing a check mark next to the following questions:**

_____I have a fear of needles.

_____I have a genetic bleeding disorder. *Please Specify*: _____

_____I am regularly taking blood thinning (anti-coagulation) medication. Please Specify: _____

____I am regularly taking pain relievers. *Please specify*: _____

I have read this Patient Information and Consent form carefully**. I understand this procedure is not acupuncture** and I have had an opportunity to ask questions and obtain any desired clarification. I consent to having the procedure of Dry Needling performed on me. I give permission to have the treated region(s) photographed for records/educational purposes.

_____ _____
Patient or Authorized Representative Date

_____ _____
Relationship to patient (if other than patient) (Patient name printed)

If patient is less than 18 years of age parent or legal guardian must sign