CHIROPRACTIC REGISTRATION AND HISTORY

BONT CHIROPRACTIC
144 North Adams Street
St. Croix Falls, WI 54024
(715) 483-3913

1 PATINET INFORMATION

Date_____/_____/_____ SS# _____-_____-_____

E-Mail_____

Patient Name_____
Last name

_____
First Name Middle Initial

Address_____

City_____ State_____ Zip_____

Sex ❒ M ❒ F Age _____ DOB _____/_____/_____

❒ Married ❒ Widowed ❒ Single ❒ Divorced ❒ Minor

Patient Occupation_____

Employer/School_____

Employer/School Phone (_____)_____

Employer/School Address _____

City _____ State _____ Zip _____

MINOR RESPONSIBLE PARTY

Name_____

Relationship to Patient_____ Phone (_____)_____

Address_____

City _____ State _____ Zip _____

Occupation _____

Employer/School _____

Whom should we thank for referring you? _____

2 INSURANCE INFORMATION

Policy Holders Name_____

Relationship to Patient _____DOB ____/____/____

Subscriber's SS# _____-_____-_____ Male / Female

Primary Insurance Co. _____

Policy # _____ Group # _____

Is the patient covered by additional insurance? ❒ yes ❒ no

Policy Holders Name_____

Relationship to Patient _____DOB ____/____/____

Subscriber's SS# _____-_____-_____ Male / Female

Second Insurance Co. _____

Policy # _____ Group # _____

ASSIGNMENT AND RELEASE

I Certify that I, and/or my dependent (s), have insurance coverage with above Insurance company (ies) and assign directly to **Dr. Steven S. Bont** all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am Financially responsible for all charges whether or not paid by insurance. I agree to pay for services not covered by insurance and understand that I am responsible for payment in full.

The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will apply to all services until it is revoked in writing.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Ph.(_____) _____ Home Ph.(_____) _____

Cell Phone Carrier: ATT VERIZON SPRINT OTHER_____

IN CASE OF EMERCENCY, CONTACT

Name _____Relationship_____

Home Ph.(_____)_____ Work Ph. (_____) _____

Physician's Name _____

Physician's Phone _____

4 ACCOUNT INFORMATION

Is condition due to an accident? ❒ Yes ❒ No Date_____

Type of accident ❒ Auto ❒ Work ❒ Home ❒ Other

To whom have you made a report of your accident?

❒ Auto Insurance ❒ Employer ❒ Works Comp ❒ Other

Attorney Name (if applicable) _____

_____

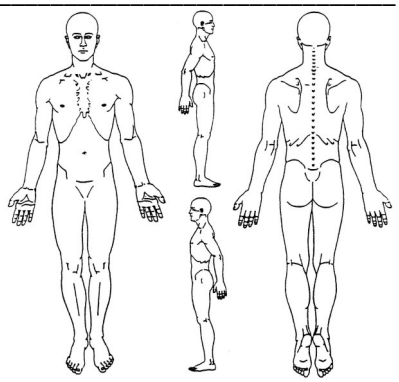
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear?_____

Is the condition getting progressively worse? ❒ Yes ❒ No ❒ Unknown

Mark an **X** on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) 10 (severe pain) _____

Type of pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting

❒ Burning ❒ Cramps ❒ Tingling ❒ Stiffness ❒ Swelling ❒ Other _____

How often do you have pain?_____

Is it constant or does it come and go? _____

Does it interfere with your ❒ Work ❒ Sleep ❒ Daily Routine ❒ Recreation

Activities or movement that are painful to perform ❒ Sitting ❒ Standing ❒ Walking ❒Bending ❒ Laying down ❒ Other _____

Patient Name _____ Date _____

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6

HEALTH HISTORY

What treatment have you already received for this condition? ❒ Medications ❒ Surgery ❒ Physical Therapy
❒ Chiropractic Services ❒ Other _____

Name and address of other doctor (s) who have treated you for this condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
Chest X-Ray _____ MRI, CT Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❒Yes ❒No	Emphysema	❒Yes ❒No	Migraine Headaches	❒Yes ❒No	Prosthesis	❒Yes ❒No
Anemia	❒Yes ❒No	Epilepsy	❒Yes ❒No	Miscarriage	❒Yes ❒No	Psychiatric Care	❒Yes ❒No
Appendicitis	❒Yes ❒No	Fractures	❒Yes ❒No	Mononucleosis	❒Yes ❒No	Rheumatoid Arthritis	❒Yes ❒No
Arthritis	❒Yes ❒No	Goiter	❒Yes ❒No	Multiple Sclerosis	❒Yes ❒No	Stroke	❒Yes ❒No
Asthma	❒Yes ❒No	Gout	❒Yes ❒No	Osteoporosis	❒Yes ❒No	Thyroid Problem	❒Yes ❒No
Bleeding Disorders	❒Yes ❒No	Heart Disease	❒Yes ❒No	Pacemaker	❒Yes ❒No	Tonsillitis	❒Yes ❒No
Breast Lump	❒Yes ❒No	Hepatitis	❒Yes ❒No	Parkinson's Disease	❒Yes ❒No	Tuberculosis	❒Yes ❒No
Bronchitis	❒Yes ❒No	Hernia	❒Yes ❒No	Pinched Nerve	❒Yes ❒No	Tumors, Growths	❒Yes ❒No
Cancer	❒Yes ❒No	Herniated Disk	❒Yes ❒No	Pneumonia	❒Yes ❒No	Ulcers	❒Yes ❒No
Chem. Dependency	❒Yes ❒No	Hight Cholesterol	❒Yes ❒No	Polio	❒Yes ❒No	Other	❒Yes ❒No
Diabetes	❒Yes ❒No	Kidney Disease	❒Yes ❒No	Prostate Problems	❒Yes ❒No		

EXERCISE
❒ None
❒ Moderate
❒ Daily
❒ Heavy

WORK ACTIVITY
❒ Sitting
❒ Standing
❒ Light Labor
❒ Heavy Labor

HABITS
❒ Smoking Packs/Day_____
❒ Alcohol Drinks/Week _____
❒ Coffee/Caffeine Drinks Cups/Day _____
❒ High Stress Level Reason _____

Are you pregnant? ❒ Yes ❒ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Surgeries		
Auto Accidents		

CURRENT MEDICATIONS	ALLERGIES	VITAMINS/MINERALS

Pharmacy Name _____ Pharmacy Phone _____

I request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy, rehabilitation, and diagnostic X-rays on myself or the patient named above for whom I am legally responsible, by the doctor of Bont Chiropractic LLC. I Understand and am informed that, like any health care related procedure, there are some risk to treatment. Risks include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains. I understand that chiropractic is not an exact science and that every patient responds to care differently, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatments that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

SIGNATURE: _____

St. Croix Falls Office
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PO Box 579
St Croix Falls, WI 54024

Bont Chiropractic

Dr. Steven Bont

Phone
715-483-3913
Fax
715-483-3098

I, the undersigned patient, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which a third-party payer can verify that services billed were provided
- A toll for routine healthcare operations such as assessing quality and reviewing that competence of healthcare professionals, and
- A marketing tool solely by Bont Chiropractic in the form of newsletters, mailings, etc.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the fallowing restrictions to the use or disclosure of my health information:

I fully understand and Accept / Decline the terms of this consent.

Signature _____ Date _____

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INFORMED CONSENT FOR BONT CHIROPRACTIC

PATIENT NAME:_____ Date:_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The Primary treatment I use as a doctor if chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hand or a mechanical instrument upon your body in such way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment **** Patient must initial EACH procedure they are consenting to be performed.****

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

_____Spinal Manipulative Therapy	_____Palpation	_____Vital Signs
_____Range of Motion Testing	_____Orthopedic Testing	_____Basic Neurological Testing
_____Muscle Strength Testing	_____Postural Analysis	_____EMS
_____Ultrasound	_____Hot / Cold Therapy	_____Radiographic Studies

_____Other (Please explain) _____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations 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. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of you history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and on in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time the process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. **PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read ( ) or have had read to me ( ) the above explanation of chiropractic adjustment and related treatment. I have discussed it with Dr. Steven Bont 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 decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

_____
Patient Name

_____
Patient Signature

_____
Date

_____
Dr. Steven S. Bont, DC

_____
Date