Dr. Maria Yiassemides

Registration Form

Today's Date: _____/_____/ 20_____

Patient Information

Patient Name: _____ Date of Birth: _____/ _____/ _____

Gender: Male Female *Marital Status:* Married Single Divorced Separated Widowed

SSN: _____

Address: _____ Apt #: _____

City: _____ *State:* _____ *Zip:* _____

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____

Email Address _____

Occupation: _____ *Current Employer:* _____

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

Height: _____ *Weight:* _____

In Case of Emergency Contact:

Name: _____ *Phone:* _____

Relationship to Patient: _____

Referred to our office by _____

Primary Care Physician: _____

Office Address: _____ *Office Phone:* _____

Nature of Illness:

Work Related ___ Auto Accident ___ Other ___

Date of onset: _____/_____/20_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Maria Yiassemides or insurance company to release my information required to process my claims.

Patient/Guardian Signature: _____

Printed Name: _____ Date: _____/_____/20_____

Dr. Maria Yiassemides

Patient's Name: _____

Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

Relationship to Policy Holder: _____

Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

Relationship to Policy Holder: _____

Patient Responsibility – Insurance Disclaimer

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment of that service. We suggest to all patients that they contact their insurance to confirm that these services are covered.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for services, you agree to pay for the services provided by our office.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payments for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. I further understand that excessively overdue accounts will be forwarded to an outside collections agency and I will be responsible for any fees generated as a result of collection efforts.

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices that provides a complete description of information uses and disclosures.

Authorization of Benefits of Records

I hereby authorize Maria Yiassemides D.C. to furnish my attorney and/or insurance carrier with any and all medical information, bills and/or records necessary for payment of services rendered to me or my dependent(s). I also authorize any company that is in any way involved with any aspect of my claim to disclose any and all aspects of my claim to Maria Yiassemides D.C. so that appropriate status may be determined in the processing of my diagnosis, treatment and/or claim.

Assignment of Benefits/Doctors Lien

I understand that health and accident policies are an arrangement between my attorney and/or insurance carrier and myself. Furthermore, I understand the office of Dr. Maria Yiassemides will assist me in submitting claims to my attorney and/or insurance company. I hereby authorize and request payments of benefits by my insurance company(s) and/or my attorney be made directly to Dr. Maria Yiassemides for services furnished to me or my dependent(s).

X _____ Date: _____

Patient's Signature

X _____ Date: _____

Guardian/Representative's Signature

Treatment for Minors (17 years of age and younger):

I hereby authorize Dr. Maria Yiassemides to administer treatment as she so deems necessary to my child,

_____.

First and Last Name

I acknowledge that I am the parent or legal guardian and I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I have read this form and certify that I understand its contents.

Patient/Legal Guardian Name (print): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

INFORMED CONSENT

To the patient: 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 of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This 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

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: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 treatments. 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 your 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 one in five million cervical adjustments. The other complications are also generally described as rare.

The risks 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 this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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 hereby give my consent to that treatment.

Patient's Signature: _____ Date: _____

Patient's Name: _____

Chiropractic Problem: (Describe)

_____

_____

How long have you had this condition?	Is it getting worse? ☐ Yes ☐ No	Does it bother your: ☐ Work ☐ Sleep ☐ Other (Specify)	
What seemed to be the initial cause?			
Have you seen a chiropractor before? ☐ Yes ☐ No	If yes, how long ago?	For what reason?	
Are you under the care of a physician? ☐ Yes ☐ No	If yes, for what?		
Have you been hospitalized in the last 5 years? ☐ Yes ☐ No	For major surgery? ☐ Yes ☐ No	For serious injury? ☐ Yes ☐ No	Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Drugs you now take: ☐ Birth control pills ☐ Tranquilizers ☐ Painkillers ☐ Others			
Do you wear: ☐ Heel lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ Negative Heels ☐ Platform Shoes			
Age of your mattress:	☐ Comfortable ☐ Uncomfortable	Do you use a bedboard? ☐ Yes ☐ No	
How is most of your daytime spent?: ☐ Standing ☐ Sitting ☐ Walking ☐ Other (specify)			

PUT AN X IN FRONT OF THOSE SYMPTOMS YOU NOW HAVE:

- ☐ Headache
- ☐ Neck Pain
- ☐ Pain between shoulder blades
- ☐ Low back pain
- ☐ Allergies
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Nausea
- ☐ Vomiting
- ☐ Bursitis
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Gain of Weight
- ☐ Nervousness / Depression
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Constipation
- ☐ Diarrhea
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Heart / Circulatory Disease

DO YOU HAVE PAIN OR NUMBNESS IN:

- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Tailbone

HAVE YOU EVER:

	Yes	No	If yes, explain briefly
Had a broken bone?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Had strains or sprains?	☐	☐	_____
Had a cane, crutch or other support?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____

DO YOU:

	YES	NO	
Take minerals, herbs or vitamins?	☐	☐	_____
Think you needs minerals, herbs or vitamins?	☐	☐	_____
Have any drug allergy?	☐	☐	_____

HABITS

	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐

WHEN DID YOU LAST HAVE:

	Never	0-5 mo	6-18 mo	Longer
Spinal x-ray	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐

FEMALE ONLY: Are you pregnant? ☐ Yes ☐ No

If yes, how long? _____

Number of Children: _____

Periods Irregular? ☐ Yes ☐ No