Bryant Chiropractic and Massage
1150 140th Ave. NE, Suite 101
Bellevue, WA 98005
Phone: 425- 890- 0142; Fax: 425- 412- 4949
Dr. Randy Bryant, DC

Patient Registration

Date: _____

Patient Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Telephone#: Home: _____ Cell: _____ Work: _____

Best contact telephone: Cell/ Home/ Work

Best time to call: Anytime/ Morning/ Lunch Time/ Evening/ Between: _____

E- mail: _____

Contact by e-mail or text message:

Appointment reminders: □ Yes □ No / **Messages**: □ Yes □ No / **Clinic Announcements:** □ Yes □ No

Driver's License/ (ID) #:_____ SSN: _____ - _____ - _____

Insurance Name and ID#/ Claim Number: _____

Date of Birth: _____ Age:_____ □ Male □ Female

□ Married □ Single □ Divorced □ Widowed □ Other _____ Number of Children: _____

Type of Injury: □ Auto Accident □ Work □ Sports □ Fall □ Chronic pain □ Other _____

Date of Injury: _____

Pregnancy and Postpartum Patients:

Estimated Due Date: _____ Delivery Date: _____

If you have insurance coverage, please understand that this is an agreement between you and your insurance company. You are responsible for all charges and payments of your bill, regardless of the status of your claim. All co-payments are due at the time of service unless other arrangements have been made.

Signature: _____ Pt #: _____

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BASIC HISTORY

Patient Name: _____ **Date:** _____

Date of Illness/Injury*:* _____**Date of Birth:** _____ **Age:** _____**Sex:** F/M

Single/Married? Children:_____ **Occupation:**_____

How did your current pains begin?

_____

_____

_____

What areas are you currently having pain? Please describe the pain (dull/sharp/aching/numb/burning/stabbing/radiating/shooting/etc).

Area 1:_____

Area 2:_____

Area 3:_____

Area 4:_____

What kind of care have you had from the time of injury until now for each area?

_____

_____

Has anything helped/worsened the pain?

_____

What activities are painful to perform? (circle and number the circle for all that apply)

Sitting / Walking / Standing / Bending / Lying Down

Does the pain interfere with*:* WORK / SLEEP / DAILY ROUTINE

How frequent is your pain?	**Area1**	**Area2**	**Area3**	**Area4**
INTERMITTENT (less than 25% waking hours)	_____	_____	_____	_____
OCCASIONAL (25% to 50% of waking hours)	_____	_____	_____	_____
FREQUENT (50% to 75% of waking hours)	_____	_____	_____	_____
CONSTANT (75% to 100% of waking hours)	_____	_____	_____	_____

Pain is:	**Area1**	**Area2**	**Area 3**	**Area4**
Worsening:	_____	_____	_____	_____
Same:	_____	_____	_____	_____
Improving:	_____	_____	_____	_____

Have you had any injury aggravations, re-injuries or complicating new injuries?

_____

_____

Have you had a history of current complaints before?

_____

_____

_____

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Patient Name: _____ **Date:** _____

Health History (1 of 2)

Please take the time to fill in this information. It really helps streamline the visit.

How long has it been since your last medical evaluation?: _____
Do follow any special diet? If yes, please describe: _____

	Yes	No	
Tobacco?	☐	☐	If yes, how much/many per day? _____ for how many years have you used tobacco? _____
Alcohol?	☐	☐	If yes, how many drinks per week? _____
Caffeinated drinks?	☐	☐	How many per day? _____
Regular exercise?	☐	☐	Please describe: _____ _____

Please list any **allergies** or **sensitivities** to medications: Tic here if none: ☐

Allergy:	**Type of reaction:**
_____	_____
_____	_____
_____	_____

Current Medications (prescription & non-prescription, please include dose):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Herbs or supplements

_____ _____
_____ _____
_____ _____
_____ _____

Personal Medical History: *Please tick the appropriate box*

	Yes	No		Yes	No
High blood pressure:	☐	☐	Gastrointestinal disorder:	☐	☐
Cholesterol problems:	☐	☐	Acid reflux:	☐	☐
Heart disease: type: _____			Stomach ulcer:	☐	☐
			Hepatitis:	☐	☐
Thyroid disorder:	☐	☐	Irritable bowel	☐	☐
Diabetes: type: _____	☐	☐	Frequent bladder infections:	☐	☐
Kidney disease:	☐	☐	Incontinence:	☐	☐

Patient Name: _____ **Date:** _____

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Health History (2 of 2)

	Yes	No		Yes	No
Anemia:	☐	☐	Respiratory problems:	☐	☐
Bleeding/clotting disorder:	☐	☐	Asthma:	☐	☐
Stroke:	☐	☐	Seasonal allergies:	☐	☐
Skin disorder:	☐	☐	Sleep problems:	☐	☐
Type: _____			Serious infections:	☐	☐
Cancer:	☐	☐	Chronic pain:	☐	☐
Type: _____			Location of pain: _____		

Other illnesses: _____

Please list any **surgeries**: _____
_____

	Yes	No
Do you have a tendency for depression?	☐	☐

If yes, what treatment has been helpful? _____

Current recent and ongoing fever/night sweats (other than recent colds/flu) or waking night pain (other than when turning/moving in bed)? (circle)

Family History:

	relationship to you		relationship to you
Diabetes	_____	Alcoholism	_____
Heart disease	_____	Depression	_____
High blood pressure	_____	Bleeding disorder	_____
High Cholesterol	_____	Strokes	_____
Prostate cancer	_____	Arthritis	_____
Breast cancer	_____	Thyroid disease	_____
Other cancers	_____	Osteoporosis	_____

Please specify any specific issues or problems you would like to address:

_____
_____

The statements made in these documents are true and accurate to the best of my recollection.

Signature _____

(Patient or Legal Guardian)

CT Initials _____

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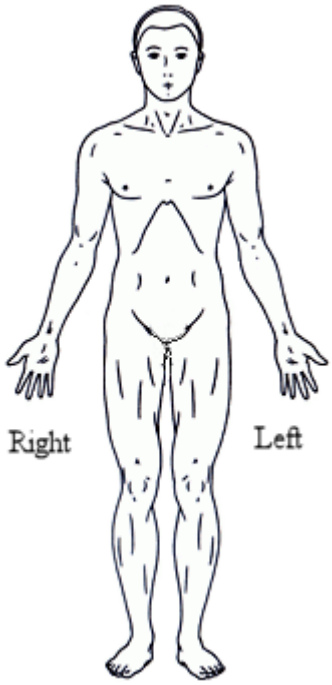
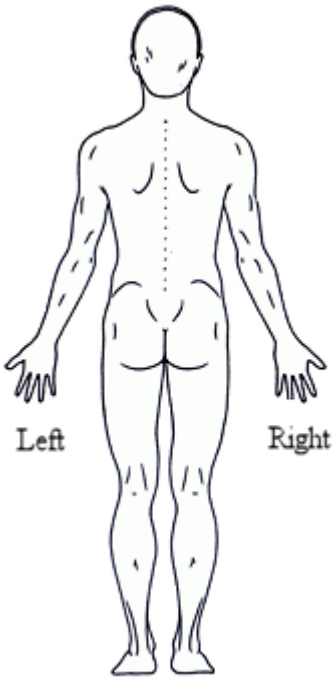
Patient Name: _____ **Date:** _____

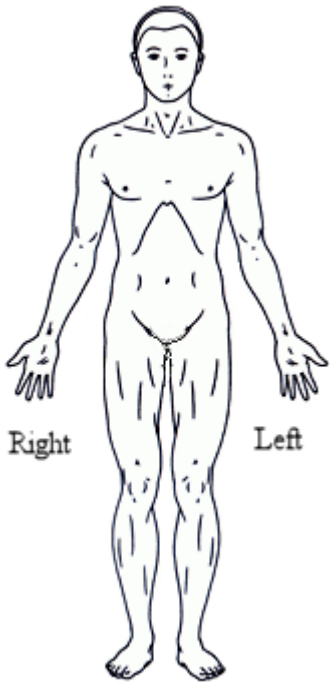
Type of Pain: __Stiffness __Burning __Numb/Tingling __Sharp __Sore/Dull/Achy

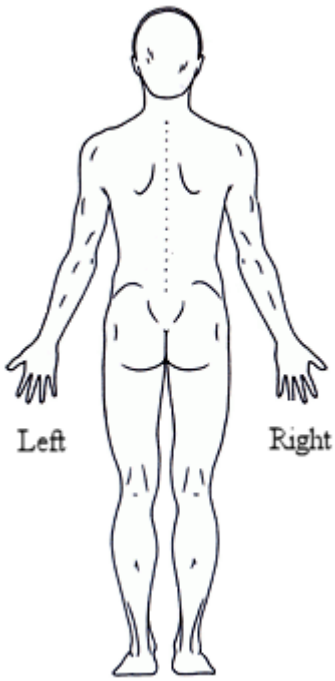
Pain Chart





Date: _____ Signature _____





Date: _____ Signature _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

RCW 18.25.005 " Chiropractic" defined.

(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care of treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.

RCW 18.25.006 Definitions.

(5) " Vertebral Subluxation Complex" means a functional defect or alteration of the biomechanical physiological dynamics in a joint that may cause neuronal disturbances, with or without displacement detectable by x-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypomobility, periarticular muscle spasm, edema, or inflammation.

(9) "Chiropractic Adjustment" means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

It is not uncommon for some patients to experience some increased discomfort after an adjustment. If that happens, I agree to apply ice on the area and rest. If I am concerned about this discomfort or develop any new symptoms, I may call the office. If I am out of town or unable to contact the doctor, I may present myself to the emergency room.

As in all health care, there are some risks to treatment including but not limited to, muscle sprain/strain, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks or complications, however the doctor will do his best to explain the problem.

Based on the facts and findings as presented to the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well being during the course of the procedures.

I have read the above consent with the doctor and/or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature:_____ **Date:** _____

(Patient, Guardian*, or Authorized Representative*)

Personnel Signature:_____ **Date:** _____

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OFFICE AND FINANCIAL POLICIES

1. 100% of your first office visit fees are payable at the time of service except for Labor & Industry claims or Motor Vehicle Accidents/Personal Injury cases, where other prior written arrangements have been made.
2. All co-payments are due at the time of service, unless other arrangements have been made.
3. If you have insurance coverage, please understand that you are responsible for all charges and payment of your bill, regardless of the status of your insurance claim. We will be glad to help you in submitting your primary insurance claim for prompt reimbursement.
4. We do not bill secondary insurance.
5. Please, inform us immediately if you have change of insurance or insurance coverage
6. In the event, if there is an overpayment by the patient, a refund will be given when insurance money has been received and a credit balance is reflected on your account.
7. Any changes or deviations from regular office charges must be in writing and signed by an authorized person.
8. Patients, late for an appointment, will be worked in or rescheduled at the discretion of the front desk receptionist.
9. Missed appointments will be documented in your treatment record. This can lead to notification of your insurance carrier, if applicable, and can result in termination of your treatment in this office. There will be a charge of $15.00 for missed appointments, which are not payable by your insurance.
10. Absolutely no smoking in the office. We ask that you please refrain from eating and/or drinking in the office and turn off all cell phones prior to seeing the doctor.
11. We would also like to make all patients aware to the fact, that upon occasion, a fill in doctor may participate in your care.
12. Be advised that if you do not have an attorney and is proceeding as a 3rd party claim, we do require a $64.00 fee for a county and satisfaction lien filing.

I have read and/or have been explained the office/financial policy. I fully understand that I am directly and fully responsible for all bills resulting from treatment. This includes any expenses, collection fees, collection costs, court costs and attorney's fees incurred in collecting any delinquent chiropractic bill.

Patient signature: _____ Date: _____
(Patient, Guardian*, or Authorized Representative*)

Personnel signature: _____ Date: _____

***Please provide documents to prove authority to sign on behalf of the patient.**

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ASSIGNMENT OF BENEFITS

I hereby assign benefits for medical/chiropractic/massage services rendered to me and I order payment by single-party check, mailed to the above named doctor/licensed massage practitioner (LMT).

I hereby give to my doctors/LMTs at Bryant Chiropractic and Massage and representatives a Special Power of Attorney to affix my signature on any checks or drafts issued by an insurance agency, health or medical plan in payment for medical/chiropractic/massage services rendered to me.

I hereby authorize the release of necessary information from any medical records to insurance carriers. A Photostat copy of this assignment and authorization is as valid as the original. THIS ASSIGNMENT IS IRREVOCABLE.

In the absence of payment, the doctor/LMPT is further assigned all Causes of Action and necessary rights to collect such benefits or payment. It is agreed that payment to the doctor/LMP, pursuant to this authorization by any company, shall discharge said company only to the extent of such payment. It is understood that this is payment toward the total charges for professional services rendered. The undersigned authorizes the doctor/LMT to contact the Insurance Company responsible for payment of any benefits for the purpose of determining the existing and extent of insurance benefits, and authorizes the release of any and all information in the possession of the Insurance Company necessary to determine the existence and/or extent of such benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Patient's printed name Patient's Signature

_____ _____
Date Insured's or Guardian's Signature

_____
Personnel Signature