

# Riverside Chiropractic & Physical Rehabilitation

## REGISTRATION FORM

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Physician \_\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )
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Email address:

Cell Phone:

Occupation	Employer	Employer Phone No. ( )
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Street Address	City	State	ZIP Code
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Chose Clinic Because/Referred to clinic by  Other \_\_\_\_\_  Insurance Plan  Hospital

Family  Friend  Close to Home/Work  Yellow Pages  Other \_\_\_\_\_

Other Family Members Seen Here \_\_\_\_\_

### INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO US)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Occupation	Employer	Employer Address	Employer Phone No. ( )
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Is this patient covered by insurance?  Yes  No

Please indicate primary insurance  Medicare  Medicaid  Blue Cross/Shield  Aetna  Cigna

United Health Care  Auto Accident  Work Injury  Other \_\_\_\_\_

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Patient's Relationship to Subscriber  Self  Spouse  Child  Other \_\_\_\_\_

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber  Self  Spouse  Child  Other \_\_\_\_\_

### IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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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 Riverside Rehab, Inc. or insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE

DATE

# Riverside Chiropractic & Physical Rehabilitation

## HEALTH HISTORY QUESTIONNAIRE

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

Previous or Referring Doctor:	Date of Last Physical Exam: _____
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### PERSONAL HEALTH HISTORY

Childhood Illness:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
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List Any Medical Problems That Other Doctors Have Diagnosed:


### Surgeries:

Year	Reason	Hospital

### Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? .....  Yes  No

*Please turn to next page*

**List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:**

Name the Drug	Strength	Frequency Taken

**Allergies to Medications:**

Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

<b>Exercise:</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
<b>Diet:</b>	Are you dieting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you on a physician prescribed medical diet? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No # of meals you eat in an average day? _____ Rank Salt Intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low    Rank Fat Intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low
<b>Caffeine:</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola    # of Cups/Cans Per Day? _____

**All questions contained in this questionnaire are optional and will be kept strictly confidential.**

<b>Alcohol:</b>	Do you drink alcohol? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____ How many drinks per week? _____ Are you concerned about the amount you drink? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you considered stopping? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever experienced blackouts? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you prone to "binge" drinking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drive after drinking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco:</b>	Do you use tobacco? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarettes - Pks/day _____ <input type="checkbox"/> Chew - #/day _____ <input type="checkbox"/> Pipe - #/day _____ <input type="checkbox"/> Cigars - #/day _____ <input type="checkbox"/> # of Years _____ <input type="checkbox"/> or Year Quit _____

**All questions contained in this questionnaire are optional and will be kept strictly confidential.**

<b>Drugs:</b>	Do you currently use recreational or street drugs? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever given yourself street drugs with a needle? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
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FAMILY HEALTH HISTORY							
	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Brothers and Sisters</b>	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandparents (Mother's Side)</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandparents (Father's Side)</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

Continued on Back Side

MENTAL HEALTH	
Is stress a major problem for you? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER PROBLEMS	
<b>Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.</b>	
<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____ <b>Recent Changes In:</b> <input type="checkbox"/> Weight _____
	<input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ <b>Other Pain/Discomfort:</b> _____ _____ _____

## Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Riverside Chiropractic & Physical Rehabilitation for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Riverside Chiropractic & Physical Rehabilitation is not required to agree to the restrictions that I may request. However, if Riverside Chiropractic & Physical Rehabilitation agrees to a restriction that I request, the restriction is binding on Riverside Chiropractic & Physical Rehabilitation.

I have the right to revoke this consent, in writing, at any time, except to the extent that Riverside Chiropractic & Physical Rehabilitation has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Riverside Chiropractic & Physical Rehabilitation's Notice of Privacy Practices prior to signing this document. The Riverside Chiropractic & Physical Rehabilitation's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Riverside Chiropractic & Physical Rehabilitation. This Notice of Privacy Practices also describes my rights and the Riverside Chiropractic & Physical Rehabilitation's duties with respect to my protected health information.

Riverside Chiropractic & Physical Rehabilitation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

# Riverside Chiropractic & Physical Rehabilitation

200 East Girard Avenue  
Philadelphia, PA 19125  
Phone 215.291.1578  
Fax 215.291.4262  
Email [bogs@netreach.net](mailto:bogs@netreach.net)

## Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments, manual medicine procedures and any other medical procedures including but not limited to examination tests, diagnostic testing, consultations, referrals and physical therapy procedures on me (or on the patient named below for which I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment/treatment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strains and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck possibly leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the treatment as to the application of procedures, based on the facts then known, which are in my best interest.

I have had an opportunity to discuss with the doctor named below the nature and risks of the procedures that will be applied during my care and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the treatment to be provided. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself 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. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Riverside Chiropractic &  
Physical Rehabilitation

Dr. David Bodoff, D.C.  
\_\_\_\_\_

200 East Girard Ave.  
Phila., PA 19125

714 Market St.  
Phila., PA 19106

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date