REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: □ M □ F Age: ____ Birthdate: _____ □ Single □ Married □ Widowed □ Separated □ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to **American Back Institute/NUVO Health** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache R51	Feet/Hands Cold R20.9	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain(R07.82)	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing (H93.19)	Eye strain/pain	Double vision
Upper back pain M54.03	Shortness of breath	Loss of smell
Lower back pain M99.83/M54.5	Fear	Chest pain
Midback pain M99.82/M54.04	Confusion	Neck pain M99.81/M54.2
Pins and needles in hands right/left (R20.2)	Pins and needles in arms right/left (R20.2)	Pins and needles in legs right/left (R20.2)

Medical Implants: _____ **Medical alerts: _____**
Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Name: _____ Date: _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:
Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

Fatigue and Pain

Place a check beside any issues that you are currently experiencing:

☐ Tired in the morning or feel unrefreshed after sleeping (G47.9)
☐ Feel run down most of day (R53.83)
☐ Pain, Unspecified (R52)
☐ Fatigue (R53.83)
☐ Loss of memory or concentration (R41.840)
☐ Use opiate pain medicine daily (Z79.891)
☐ Numbness or tingling in extremities (R20.2)
☐ Excessive snoring (R06.83)
☐ Inability to get enough sleep due to stress, pain, or other condition (F51.0)
☐ Feel pain most of the time (G89.29)
☐ Leg pain (M79.606)
☐ Constipation due to pain medicine (K59.03)
☐ Upper back pain (M54.89)
☐ Neck pain (M54.2)
☐ Joint pain (M25.50)
☐ Headaches (R51)
☐ Physical need for opiate daily (F11.20)

Heart and Lung

Place a check beside any issues that you are currently experiencing:

☐ Inability to walk without losing breath (R06.09)
☐ Need to use multiple pillows to help breathe at night (R06.01)
☐ Wheezing (R06.2)
☐ Asthma (J45.998)
☐ Cough (R05)
☐ Dyspnea, Unspecified (R06.00)
☐ Chest pain when breathing (R07.1)
☐ Coughing up blood (R04.2)
☐ Coughing up black sputum (R09.3)
☐ Pain or tightness in chest (R07.89)
☐ Previous heart attack (I25.2)
☐ Essential Primary Hypertension (I10)
☐ High blood cholesterol (E78.00)
☐ Enlarged heart (I51.7)
☐ Swelling in legs/ ankles (R60.0)
☐ Bulging veins in neck (I87.8)
☐ Heartburn or reflux (R10.13)
☐ History of high blood pressure (I10)
☐ Tachycardia (R00.0)
☐ Bradycardia (R00.1)
☐ Palpitation in chest (R00.2)
☐ Irregular heart rate (I49.9)
☐ History of congestive heart failure (I50.9)
☐ Emphysema

Gastrointestinal

Place a check beside any issues that you are currently experiencing:

☐ Heart burn/ gastric reflux (K21.9)
☐ Ulcers in esophagus or stomach (K25.9)
☐ Impaired digestion, nausea and vomiting (K30)
☐ Irritable bowel syndrome (K58.8)
☐ Constipation (K59.00)
☐ Diarrhea (K59.1)

☐ Stomach discomfort due to eating certain foods (K52.21)
☐ Gall bladder attack (K80.21)
☐ Lactose Intolerance (E73.9)
☐ Rectal bleeding (K62.5)
☐ Hemorrhoids (K64.9)
☐ Crohn's Disease (K50.00)

Psychological / Sexual

Place a check beside any issues that you are currently experiencing:

☐ Excessive stress (R45.7)
☐ Irritability (R45.1)
☐ Depressed (F32.9)
☐ Anxiety (R45.82)
☐ Insomnia (F51.01)
☐ Feel burned out (R53.83)
☐ Use of recreational drugs (F12.99)
☐ Low motivation (R45.84)
☐ Lack sexual desire (F52.0)
☐ Low libido (R68.82)
☐ Sexual dysfunction (R37)
☐ Use of oral contraceptives (Z79.3)
☐ Use of antidepressant medications (Z79.899)
☐ Erectile Dysfunction (N52.9)
☐ Premature ejaculation (F52.4)
☐ Painful ejaculation (N53.12)
☐ Inability to ejaculate (N53.11)
☐ Female- inability to achieve orgasm (F52.31)
☐ Vaginal dryness/ painful intercourse (F52.6)
☐ History of sexually transmitted infections (A64)

Metabolic & Other Disorders

□ Diabetes x _____ years
□ thyroid problems
□ sickle cell disease
□ high cholesterol or lipids
□ skin disorder _____
□ psoriasis
□ any skin ulcer
□ tooth abscess, gingivitis
□ depression
□ anxiety
□ alcohol or drug dependency
□ other: _____

Cancer : any type -- please specify
_____
Other medical problems NOT included above (explain)
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems. Circle M Mother F Father S Sibling (Brother/Sister) GM Grandmother GF Grandfather

□ asthma M F S GM GF □ tuberculosis M D S GM GF □ sleep apnea M F S GM GF
□ COPD or Emphysema □ other lung :_____ M F S GM GF
□ heart attack, myocardial infarction M F S GM GF □ congestive heart failure M F S GM GF
□ irregular heartbeat, arrhythmia M F S GM GF □ bleeding problems M F S GM GF
□ Peripheral neuropathy □ MS or Parkinson's □ other neuro :_____ M F S GM GF
□ osteoarthritis M F S GM GF □ Lupus M F S GM GF □ gout M F S GM GF
□ rheumatoid arthritis □ Other bone & joint: _____ M D S GM GF
□ acid reflux, **GERD** M F S GM GF □ inflammatory bowel disease M F S GM GF
□ hepatitis - Type _____ M F S GM GF □ liver disease M F S GM GF
□ other GI :_____ M F S GM GF
□ kidney problems □ dialysis, kidney failure M F S GM GF
□ diabetes M F S GM GF □ psoriasis M D S GM GF □ thyroid problems M F S GM GF
□ high cholesterol or lipids M F S GM GF □ sickle cell disease M F S GM GF
□ any skin ulcer M F S GM GF □ Malignant hyperthermia M F S GM GF
Cancer : any type -- please specify M F S GM GF
_____
Other medical problems NOT included above (explain) M F S GM GF
_____
_____

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

____ I do not have insurance. I would like to apply for the Discount Medical Organization (DMPO) WellCare Network and receive discounts on my treatment, or

____ I do not have medical insurance, and I want to pay full list price for my care.

Work or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

Attorney Phone #: _____

***Person to contact in an emergency (Name and Phone #): _____**

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. David Wade, DC/ American Back Institute, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. If collection of my account becomes necessary, then I authorize the above named clinic to charge collection fees and legal fees and interest to my account or for this clinic to assign the collection to an outside agency and add their collection fees.

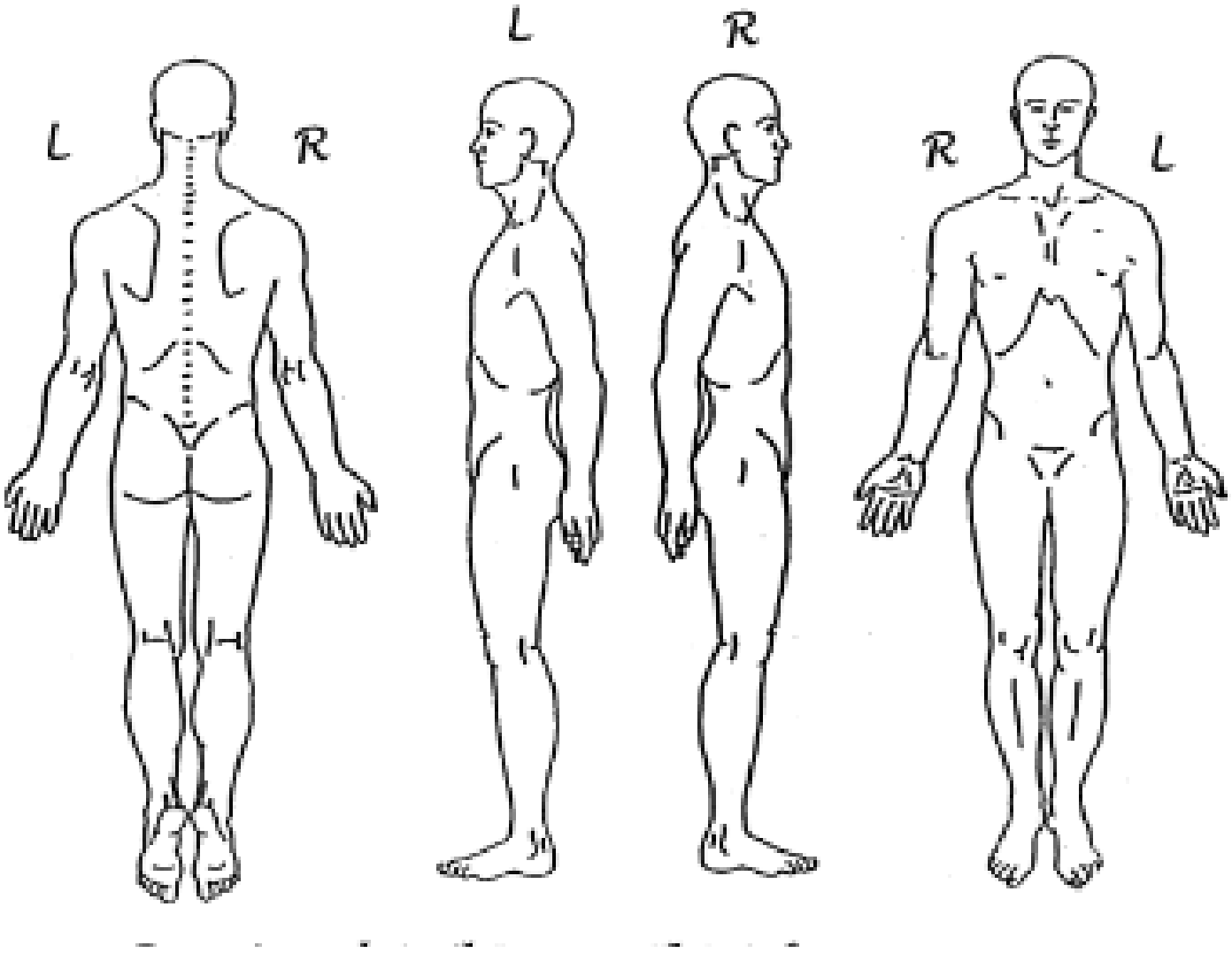
I further agree to inform the doctor/office of any change in insurance or legal representation.

_____ _____

Signature of Insured / Guardian Date

BODY PAIN DIAGRAM

Please mark the diagram below showing where you have any pain or discomfort.



NAME _____

DATE _____

Directions to the office: We are located at 114 Hamric Dr. East, Suite E, on Hwy 78 in Oxford, just past Western Sizzling, between Oxford Muffler and Oxford Housing in the Plaza opposite of the Mexican Store.