PATIENT REGISTRATION FORM PAGE 1

201 Wilshire Blvd. Suite A35,
Santa Monica, CA 90401 ph.: 310-255-0411

Patient Name ____ Birthdate ________________ Sex M F
Email Address ____ Social Security # ______/_____/__________
Address ____ City______________________________
State ______ Zip ______________ Mobile Phone# (_____)_______________
Occupation ____________________________Employer______________________Work Phone (____)___________________
Health Plan_________________ Subscriber Name____________________ Subscriber ID ___________________ Group #__________
Spouse Name_______________________ Spouse Employer______________________________
Primary Care Physician Name ____________________PCP Phone# (_____)___________________
Emergency Contact Name _____________________ Emergency Contact Phone# (_____)__________________

If you were in an Accident: Date of Accident: _______ City &State: ______________ Claim #__________________________
Insurance Company Name: __________________________ Contact Person _______________Contact #________________
Attorney Name: ______________________________________ Attorney Phone #: (_______) ___________________
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:_
❑ Headache ❑ Neck Pain ❑ Mid-back Pain ❑ Low Back Pain ❑ Other ___________
Is this? ❑ Work Related ❑ Auto Related ❑ N/A
Date Problem Began: __________ How Problem Began:______________________________________

Current complaint (how you feel today):	In the past week, has your pain interfered with your daily activities (e.g., work, social activities. or household chores?)
0 1 2 3 4 5 6 7 8 9 10 0= No Pain 10= Unbearable Pain	0 1 2 3 4 5 6 7 8 9 10 0=No Interference 10=Unable to carry out any activities

How often are your symptoms present? (Intermittent) ❑ 0 — 25% ❑ 26 — 50% ❑ 51 — 75% ❑ 76 — 100% (Constant)

Is the pain progressively getting worse? Yes No Have you seen any other doctors for this condition? ____________________
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ❑ No ❑ Yes
Date(s) taken: __________________ what areas were taken? ______________________________
PAST HEALTH HISTORY: Please Check and Describe:

Major Surgery/Operations □ Appendectomy □ Back Surgery □ Broken Bones □ Other _______ Major Accidents/Falls____________
MEDICATIONS:____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have health insurance coverage with _______and assign directly to Dr. Pamela Ramer, DC, all insurance 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 my health or auto insurance, any third party insurance, the adjuster and to my attorney to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In addition, I hereby grant you a voluntary and irrevocable lien against my share of the proceeds of any settlement or award resulting from the disposition of any claim which I may have arising from the captioned accident in which I was involved, and on any amounts available for medical payments under my various insurance coverages, including but not restricted to my automobile insurance and assignment of benefits for all my insurances and the right to cash all insurance checks & accident/claim reimbursement checks made out jointly with me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, my fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

Patient's Signature ____ Date _______________

Consent to Treat a Minor, Guardian or Spouse's Signature Authorizing Care:
Name: _____________________ Relationship ______________Signature _____________________ Date _______________

Ramer Chiropractic
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Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE LAST SIX MONTHS:

MUSCLO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTROINTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Programs
- ☐ Irregular Heartbeat
- ☐ Heart Programs
- ☐ Lung Programs/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Programs
- ☐ Dental Programs
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY:

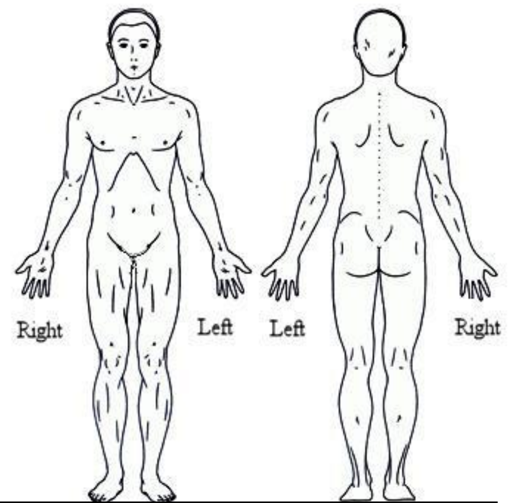
When was your last period? ________________

Are you pregnant?
☐ Yes ☐ No

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate Sexual Dysfunction
- ☐ Other Problems
- ☐ ______________________
- ☐ ______________________

Please outline on the diagram the area of your discomfort



A: Achy B: Burning N: Numbness
P: Pins & Needless S: Stabbing O: Other

Family History:

Cancer___ Diabetes___ Blood Pressure__
Heart Problems___ Stroke__
Rheumatoid Arthritis___ Other____________

Patient Signature________________ Date:_________

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HIPPA FORM

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Ramer Chiropractic/Dr. Pamela Ramer

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

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. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor 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 have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. 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 Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Ramer Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor 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 of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name: ________________________________

Signature: _________________________________

Date: _________________________________

INFORMED CONSENT DOCUMENT

Dr. Pamela Ramer, DC, 201 Wilshire Blvd. A 35, Santa Monica, CA 90401

PATIENT NAME: ___________________________

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. 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

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

Please read carefully and initial each procedure.

___ Instrument Adjusting	___ palpation	___ vital signs	___ postural analysis testing
___ spinal manipulative therapy	___ basic neurological	___ Yoga	___ muscle strength testing
___ range of motion testing	___ hot/cold therapy	___ EMS	___ radiographic studies
___ Therapeutic Exercises	___ ultrasound	___ Cold Laser	___ 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 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 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 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 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.

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 the chiropractic adjustment and related treatment. I have discussed it with *(insert doctor's name)* 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 hereby give my consent to that treatment.

________________________	**Pamela H Ramer, DC**	**Date:** ___________________
Patient's Name	**Doctor's Name**	
________________________	________________________	____
Patient Signature	**Doctor's Signature**	**Signature of Parent or Guardian (if a minor)**

Thank you for becoming a part of the Ramer Chiropractic family