Dr. Borman and Associates, P.C.
1873 S. Bellaire St. #1220 • Denver, CO 80222
Phone: 303.759.8514 • Fax: 303.759.1813
www.drborman.com

NEW PATIENT REGISTRATION

Today's Date_____

Name_____
Last First Middle

(Complete Mailing)
Address_____**
Street Apt# City State Zip

Social Security # _____ – _____ – _____ Date of Birth_____

Home Phone # (_____)_____–_____** Work Phone # (_____)_____–_____**

Cell Phone # (_____)_____–_____** E-mail Address: _____**

Emergency Contact_____ Relationship_____ Phone# (_____)_____–_____

Employer_____ Occupation_____ Phone# (_____)_____–_____

Is this visit routine/accident/illness/other: _____ If Accident (date) _____

Name of Insurance_____ ID#_____ Grp#_____

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. _____ I hereby authorize Dr. Borman and Associates, P.C. to provide Chiropractic Services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Dr. Borman and Associates, P.C.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Dr. Borman and Associates, P.C., 1873 S. Bellaire St. #1220, Denver, CO 80222

5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

6. _____ I understand that Dr. Borman and Associates, P.C. has a 24 hour cancellation policy and that my account may be charged for appointment cancellations with less than 24 hours notice.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____day of _____ 20_____.

Patient Signature **Guarantor Signature** **Relationship to Patient**

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RESPONSIBLE PARTY INFORMATION
****If responsible party is different from patient****

Name (Guarantor)_____
Last First Middle

Relationship to Patient _____

Address _____ Phone# (_____)_____ - _____
Street City State Zip

Employer_____

Address_____ Phone #(_____)_____ - _____

Name of Insurance_____ ID#_____ Grp#_____

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ DOB _____
Patient's full name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____Witnessed by _____
(Parent or Guardian)

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PERSONAL HEALTH HISTORY

Patient's Name _____ **DOB** _____ **Date** _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history. If a condition does not apply, please leave the check boxes blank.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Women only
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐ Yes ☐ No

Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?

Medications? ☐ Birth control pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Thinners

☐Other OTC or prescription(specify name, dosage and purpose)_____

_____

How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Patient's Name _____ **DOB** _____ **Date** _____

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been hospitalized for other than surgery?	☐	☐	
Do you:			
- take minerals, herbs or vitamins?	☐	☐	
- have any drug allergy?	☐	☐	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray/MRI/CT?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

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

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

_____

_____

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.(Diabetes, Heart Attack, Stroke, Hypertension, Cancer, etc.)

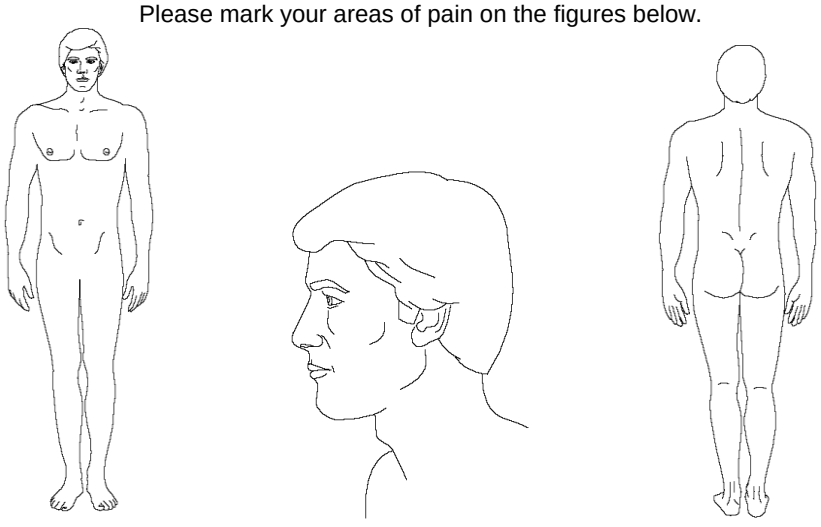
RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Describe chiropractic problem: _____

_____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No
Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please 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 reason? Doctor name and address:

Please mark your areas of pain on the figures below.



How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ◄——————————————————► **Excruciating (the worst possible)**

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ consent to Dr. Borman and Associates, P.C. Clinic's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Dr. Borman and Associates, P.C. general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Dr. Borman and Associates, P.C. diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by Dr. Borman and Associates, P.C., that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Dr. Borman and Associates, P.C., but that Dr. Borman and Associates, P.C. is not required to agree to these restrictions. However, if Dr. Borman and Associates, P.C. agrees to a restriction that I request, the restriction is binding on Dr. Borman and Associates, P.C..

I have been given the opportunity to review Dr. Borman and Associates, P.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Dr. Borman and Associates, P.C. has acted in reliance on this consent.

_____
Signature of Patient/Personal Representative/Guardian

_____
Date

_____
Description of Personal Representative's Authority

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CONSENT FORM

To Our Patients:
Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient signature Date

Please read the following carefully and initial each statement.

_____ I understand that Dr. Borman and Associates, P.C. is staffed by a team of licensed chiropractors. I will receive the majority of my care under one chiropractic physician. However, there may be times when a different chiropractic physician will be involved because of vacation relief or special scheduling problems.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the chiropractic physician because it may affect care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Dr. Borman and Associates, P.C. reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

STOP HERE

Portion Below Used If Additional Information Requested & Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

Patient signature Date