2722 EASTLAKE AVENUE EAST, SUITE 360
SEATTLE, WA 98102
Ph: 206 957-4550
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Eastlake Chiropractic & Massage Center

PATIENT REGISTRATION

TODAY'S DATE _____

Full Name: Mr./ Mrs./ Ms. _____

Name You Prefer to be Called ("Nickname"): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Age: _____ Sex: Male / Female

Spouse/Partner's Name: _____

Insurance Company: _____ Telephone: _____

Name of Insured: _____

What is your Relationship to the Insured? Self/Spouse/Dependent/Other: _____

Group or Claim No.: _____

If Accident Related, Adjuster's Name: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Name of Medical Doctor: _____ Phone: _____

In case of emergency, please give the name of a friend/relative to contact (not living at same address)

Name: _____ Home #: _____ Work #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Eastlake Chiropractic & Massage Center will prepare the necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Eastlake Chiropractic & Massage Center will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current.

Signature: _____ Date: _____

Eastlake Chiropractic & Massage Center, PS

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Eastlake Chiropractic Center, PS.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

EASTLAKE CHIROPRACTIC & MASSAGE CENTER

2722 Eastlake Ave E., #360

Seattle, WA 98102

CONFIDENTIAL HEALTH INFORMATION FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE RESPONSE

YES NO

___ ___ Have you ever had a professional massage? What other ways do you relieve stress?

_____

___ ___ Do you exercise regularly or participate in any sports? If yes, what kind and how often?

_____

___ ___ Are you currently under the care of a physician? If yes please describe.

_____

___ ___ Do you take any medication (including aspirin or ibuprofen)? _____

___ ___ Do you have skin problems or allergies? _____

___ ___ Have you ever had surgery? Please list: _____

___ ___ Do you have or have you ever had cancer? F_____

___ ___ Do you have or have you ever had heart problems? _____

___ ___ Do you have varicose veins, blood clots, or any other circulatory problems? _____

___ ___ Do you have diabetes? If yes, how is it controlled? _____

___ ___ Do you have arthritis? _____

___ ___ Do you have spinal problems? _____

___ ___ Do you experience prolonged episodes of depression or other emotions? _____

___ ___ Do you have an infectious or contagious disease? _____

___ ___ Are you experiencing sleep disorders at this time? _____

___ ___ Are you pregnant? _____

___ ___ Do you wear hearing aids? _____

___ ___ Do you have any needs that require special attention? Please specify. _____

_____

___ ___ Do you have any other medical condition that I should be aware of? _____

_____

I understand that the massage practitioners do not diagnose illness, disease, or physical or mental disorder, Massage practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it's recommended that I see a physician for a physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health.

Signature: _____

Date _____

Print Name: _____