

# Patient Registration

**Family Chiropractic**  
Terron Griffis, D.C.

204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501  
Tel: (360) 352-8112 • Fax: (360) 352-8113

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female SSN: \_\_\_\_\_

Name Suffix:  Jr.  Sr. (If applicable)

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Personal Email: \_\_\_\_\_

Preferred Communication:  Phone  Mail/Letter  Email  Fax  Decline

Confidential Communications:  Home  Work  Mobile  Email  Mail  Decline

### How would you like to receive appointment reminders?

Text Message  Email  I choose to decline appointment reminders.

Marital Status:  Single  Married  Other

Employment Status:  Employed  FT Student  PT Student  Retired  Self Employed  Other

Professional Title: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Practice name? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Can we send them a thank you note for referring you to us? Yes or No

### Patient Demographics:

**Race:** (check one or more)  White  American Indian/Alaskan Native  Black/African American  
 Native Hawaiian or other Pacific Island  Asian  Decline

**Ethnicity:** (check one)  Hispanic or Latino  Not Hispanic or Latino  Decline

**Preferred Language:** (list) \_\_\_\_\_  Decline

**Smoking:** (check one)  Current Sometimes Smoker  Never Smoker  Smoker, Current Status Unknown  
 Unknown if Ever Smoked  Heavy Smoker  Light Smoker

Current daily Smoker: What is the frequency that you smoke? \_\_\_\_\_ Packs/Day

Former Smoker: Smoking End Date: \_\_\_\_\_  Decline

**Exercise:** (check one)  None  Moderate  Daily  Heavy

**Work Activity:** (check one)  Sitting  Standing  Light Labor  Heavy Labor

**Habits:** (check one)  Alcohol: Drinks/week \_\_\_\_\_  Coffee/Caffeine: Cups/day \_\_\_\_\_  High Stress Level

**Female:** Are you pregnant?  No  Yes, Due Date: \_\_\_\_\_ Last Pelvic Exam: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Briefly list your main health problems:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any known allergies:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Do you carry an Epipen?  Yes  No

Current Prescribed Medications:

Vitamins/Supplements, include dosage if known:

Name:	Dosage:	Name:	Dosage:
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	
7.		13.	

Do you have a personal or family history of diabetes, heart problems, high blood pressure or other systemic illnesses?

Injuries/Surgeries you have had:

Fall: _____	Description: _____	Date: _____
Head Injuries: _____	Description: _____	Date: _____
Broken Bones: _____	Description: _____	Date: _____
Dislocations: _____	Description: _____	Date: _____
Surgeries: _____	Description: _____	Date: _____

Please check to indicate if you have/had any of the following:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Gout             | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Multiple Sclerosis                                     | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Suicide Attempt  |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> Pinched Nerve  | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio  | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> Prostate Problems                                      | <input type="checkbox"/> Tumors           |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Prosthesis <input type="checkbox"/> Psychiatric Care   | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Measles          | <input type="checkbox"/> Rheumatoid Arthritis                                   | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Miscarriage      |   | <input type="checkbox"/> Venereal Disease |
|   |  |   |   | <input type="checkbox"/> Whooping Cough   |

Other: \_\_\_\_\_

What is your main concern for today's visit? \_\_\_\_\_

How did this start? \_\_\_\_\_

Is the pain:  Better  Worse  About the Same

How often is complaint present?  Constant (76%-100%)  Frequent (51%-75%)  Occasional (26%-51%)

Intermittent (25%-or less)

When did it start? \_\_\_\_\_

Is the pain constant?  Yes  No If not, when is it worse? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_



What makes the pain better? \_\_\_\_\_

What treatment have you received? \_\_\_\_\_

Have you seen a Chiropractor before?  Yes  No

If yes, who? \_\_\_\_\_ How long ago? \_\_\_\_\_

**Oral Pain Scale: 0-10:** \_\_\_\_\_

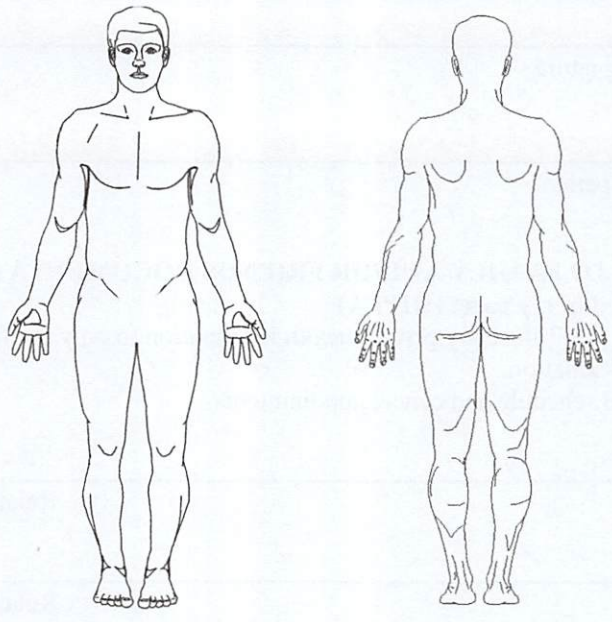
On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

**Key:**

Numbness: N

Pain: P

Tingling: T



**INFORMED CONSENT**

A patient, in coming to Family Chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment/massage or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or provide health care, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic x-rays on me (or for the patient for whom I am legally responsible) by Family Chiropractic and/or by other licensed Doctor of Chiropractic who now or in the future will treat me while employed by, working with, or associated with Family Chiropractic.

\_\_\_\_\_  
Patient/Legal Representative Signature \_\_\_\_\_  
Date



**NOTICE OF PRIVACY PRACTICE**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at 360-352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

[Redacted Signature Line]	
Patient/Legal Representative Signature	Date
[Redacted Name Line]	
Printed Name if signed on behalf of patient	Relationship

**DISCLOSURES TO FAMILY AND/OR FRIENDS DOCUMENTATION FORM**

**Family Members/Friends Involved in my care: (HIPPA)**

- 1) I agree that this office may disclose my private health information to only the following individuals listed below.
- 2) Allow them financial information.
- 3) Allow them the ability to schedule and cancel appointments.

Name	Relationship
Name	Relationship
Name	Relationship

**Financial Policy**

Welcome! Our goal is to provide you with the best possible chiropractic and massage care and to have a pleasant, positive experience for all of us. In order to serve you more effectively, we have established a few policies.

**APPOINTMENTS:** Your appointments are times reserved and committed exclusively to you. We realize emergencies do occur, and appointments must sometimes be changed. Charges MAY be made for missed appointments and appointments canceled without two hours' advance notice. (Initial) [Redacted]

**INSURANCE:** We must emphasize that as chiropractic and massage providers, our primary relationship is with you. As a service to our patients, we do accept the assignment of insurance benefits of most policies. In addition, we are participating providers with several insurance carriers and payers. YOU are responsible for payments of your co-pay at the time of service. If your deductible has not been met, YOU are responsible for full payment until it has been met; then, only your part thereafter. Once the claim has been processed by your insurance provider, we will bill you your patient responsibility part. Payment is due within 30 days of the bill. (Initial) [Redacted]

**\*\*NOTE:** *We are happy to assist you in verifying your chiropractic and massage benefits, all insurance companies begin verification with a message which states: 'This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment.'\*\**

**I RECEIVED A BILL EVEN THOUGH I HAVE SECONDARY INSURANCE:** Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.



**WHAT IF FAMILY CHIROPRACTIC DOES NOT CONTRACT WITH MY PLAN OR I DON'T HAVE INSURANCE:** If we are not a provider under your insurance plan or you don't have insurance, you will be responsible for payment in full at the time of service. You will be charged our office's time-of-service rates. At the sole discretion of the practice, extended payment agreements may be made for patients. Please speak to our office manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

**PAYMENTS:** Payment is due at the time the services are rendered unless other arrangements have been made in advance. We accept cash, checks, Visa/MasterCard, Discover/American Express. Returned checks are subject to a \$30.00 service charge. Any account that becomes delinquent will be subject to collections service. Should our clinic receive information that your insurance will no longer be covering services, such as in the incidence of maximum insurance payout met, you will be charged the applicable discounted to time-of-service rates and supplied receipts if needed.  
(Initial)

### Credit/Debit Card Authorization

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit all billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected during service. This may include a co-pay and additional payment if this practice decides that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee or service may be denied for failure to pay a co-pay or any outstanding balance at the time of service.
4. I understand that it is my responsibility to ensure that the Provider always has current information on file, including my address, contact details, insurance information, and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that I may receive a monthly statement of any outstanding balance that is not satisfied by a charge to payment method and that I am responsible for paying this balance by its due date.
7. I understand that unpaid balances may incur additional fees and interest charges.
8. I authorize Family Chiropractic to send electronic account statements, invoices, and receipts to the email address I have provided to the office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
9. I authorize Family Chiropractic to send me a text message of my current balance that is due, and I may request a statement be emailed to me at the email address I have provided to this office.
10. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to Family Chiropractic.

#### Acknowledgement and Authorization:

I have read all the information on this form and have completed on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Family Chiropractic IMMEDIATELY of any changes in my health status or the above information, including changes of insurance policies.

By signing this form, I acknowledge that I have received, reviewed, and understood Family Chiropractic's payment policies. I authorize Family Chiropractic to charge my card in accordance with the payment policy. I certify that I am an authorized cardholder or user of this credit/debit card.

Name (print) \_\_\_\_\_

Signature \_\_\_\_\_

CC Type \_\_\_\_\_ CC Number \_\_\_\_\_

CC Expr date \_\_\_\_\_ CC CVC Code \_\_\_\_\_

Approval to keep CC on file in the computer system (signature) \_\_\_\_\_

Signature if patient is a minor: \_\_\_\_\_ Date \_\_\_\_\_

Relationship if patient is a minor: \_\_\_\_\_

**Updated 1/10/2025 LG**