

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

ADULT PATIENT REGISTRATION INFORMATION

PRINTED NAME _____ DATE _____
(Last) (First) (M.I.)
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME# _____ CELL# _____ WORK # _____
DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____
Male Female / Single Married Divorced Widowed NAME OF SPOUSE _____
NAMES OF CHILDREN _____
NAME OF EMPLOYMENT _____
OCCUPATION _____ DRIVERS LICENSE # _____
HOW DID YOU HEAR OF DR. SHAAR? _____

EMERGENCY INFORMATION

NAME _____ RELATIONSHIP _____
HOME # _____ CELL # _____ WORK # _____

PAYMENT OPTIONS:

****PLEASE fill-in ALL the CURRENT billing choices for your case below.****

1) Billing Information

(List information of responsible party, if different from above.)

PRINTED NAME _____
(Last) (First) (M.I.)
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
RELATIONSHIP TO INSURED: (please circle one) SELF SPOUSE CHILD OTHER _____
PAYMENT OPTIONS: CASH PERSONAL CHECK VISA MASTER CARD

2) Major Medical Insurance Information

(* Please provide your insurance card when you arrive at the office ***)**

PRIMARY POLICY HOLDER (Name of insured) _____
INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____
INSURED'S EMPLOYER: _____
POLICY ID#: _____ GROUP #: _____
INSURANCE COMPANY: _____ INS PROVIDER PHONE #: _____

NAME _____ DATE _____

3) Auto Insurance Information

PRIMARY POLICY HOLDER (Name of insured) _____

INSURANCE COMPANY _____ AGENT _____ AGENT'S # _____

POLICY NUMBER _____ DATE OF ACCIDENT: _____

CLAIMS AGENT NAME: _____ AGENT # / EXT #: _____

FAX #: _____ CLAIM NUMBER: _____

HISTORY OF CHIEF COMPLAINT

1st) Please describe your WORST/Major/Present complaint (another section for another complaint will follow):

Result of Auto Accident: _____ **On the Job Accident:** _____ **Date of Accident:** _____

Have you ever experienced this complaint before? _____

When: _____

Where: _____

How: _____

Why: _____

What Caused It: _____

What Type of Treatment Received: _____

Diagnosis: _____

When did this current complaint start?

Has it become better, worse, or changed in any way since it started?

Describe what makes it better:

Describe what makes it worse:

NAME _____ DATE _____

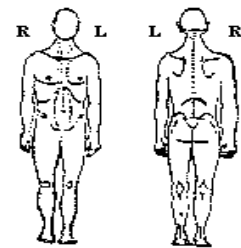
How would you describe the complaint? (mild, moderate, severe, extreme, painful, numb, stiff, achy, burning, sharp, dull, shooting, discomfort, tight, spasms, etc.)

Does it radiate spreading into other areas? (Please describe where.)

Do you have any numbness, tingling, burning, dizziness, nausea, headaches, memory loss, mood changes?

Have you ever sought chiropractic health care before? (Dr.'s name, city or state, length of care, conditions treated, x-rays taken, etc.)

Please indicate on the diagrams below where your area of chief complaint is:



Is it worse:

_____ In the morning

_____ In the mid-day

_____ In the evening

_____ Following:

_____ Routine activity

_____ Moderate activity

Does it interfere with:

_____ Work _____ Days missed

_____ Sleep

_____ Personal activities (describe) _____

_____ Activities of daily living (describe) _____

_____ Other (describe) _____

How frequent it? (i.e. daily, twice daily, three times weekly, occasional, intermittent, frequent, constant, etc.)

Please rate the intensity at its WORST on the scale below:

0 _____ 10
(absent) (extreme)

Please rate the intensity RIGHT NOW on the scale below:

0 _____ 10
(absent) (extreme)

How long does it last? (i.e. # of seconds, # of minutes, # of hours, all day, # of continuous days, etc.)

NAME _____ DATE _____

2nd) Please describe any other complaints or problems: _____

Result of Auto Accident: _____ On the Job Accident: _____ Date of Accident: _____

Have you ever experienced this complaint before? _____

When: _____

Where: _____

How: _____

Why: _____

What Caused It: _____

What Type of Treatment Received: _____

Diagnosis: _____

Additional symptoms noticed since the onset of this problem that you feel could be related?

Additional complaints you would like to discuss today: _____

Please list any quantifying and qualifying information about the above additional complaints? _____

Have you sought treatment elsewhere for this condition? (name(s), diagnosis, how it was treated, x-rays taken) _____

PATIENT PAST HEALTH HISTORY

Prior conditions requiring surgeries/operations/hospitalizations (include year):

Prior fractures/broken bones/sprained ankles (bone(s) and year): _____

Serious Adult or Childhood Diseases or Health Conditions: _____

Automobile or motorcycle injuries (injury and year): _____

Anomalies (explain/describe): _____

NAME _____ DATE _____

Significant falls/accidents/closed head trauma/concussions (injury and year): _____

Present health problems (currently under treatment): _____

Vitamins/Supplements (indicate purpose/condition): _____

All Current Medications (indicate purpose/condition/self-medicated/prescribed): _____

FAMILY HEALTH HISTORY

Please indicate **WHO** and **WHEN** in your family has or had the following conditions:

Arthritis or Bone Conditions (dx/type): _____

Blood Pressure (high or low): _____

Cancer/Tumors (location): _____

Diabetes (type or age or onset): _____

Epilepsy (type): _____

Strokes (specify): _____

Genetic Problems (specify): _____

Heart or Vascular Conditions (specify): _____

Headaches (i.e. migraines, cluster, etc.): _____

Lung Conditions (specify): _____

Alcoholism/Drug Dependency: _____

Other (specify): _____

Patient: _____

Date: _____

Patient Instructions: Please **check any significant condition** that you have ever had in the past or that you are **currently experiencing**. Please **only acknowledge** what you would consider to be **significant conditions to your health history and/or chief complaints**.

1.	General	<input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Sweats <input type="checkbox"/> Low Grade Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Water Intake: _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Normal
2.	Head	<input type="checkbox"/> Headache/Migraines <input type="checkbox"/> Trauma <input type="checkbox"/> Convulsions	<input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Fainting	<input type="checkbox"/> Pain/Discomfort <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Normal
3.	Eyes	<input type="checkbox"/> Contacts and/or Glasses <input type="checkbox"/> Color Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Double Vision <input type="checkbox"/> Poor Night Vision <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blurry Vision <input type="checkbox"/> Flashes in Front of Eyes <input type="checkbox"/> Spots in Front of Eyes <input type="checkbox"/> Eye Dryness <input type="checkbox"/> Difficulty Reading <input type="checkbox"/> Eye Strain and/or Fatigue	<input type="checkbox"/> Tearing <input type="checkbox"/> Sensitive to Lights <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Twitching <input type="checkbox"/> Normal
4.	Ears	<input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Frequent/History Infections <input type="checkbox"/> Itching/Irritation	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Drainage <input type="checkbox"/> Loud Noise Sensitivity	<input type="checkbox"/> Pain/Earache <input type="checkbox"/> Ringing <input type="checkbox"/> Normal
	Nose	<input type="checkbox"/> Post-Nasal Drip <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Changes in Smell	<input type="checkbox"/> Dryness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Congestion Sidedness	<input type="checkbox"/> Anomaly <input type="checkbox"/> Nasal Obstructions <input type="checkbox"/> Normal
6.	Mouth/ Throat	<input type="checkbox"/> Gum Bleeds <input type="checkbox"/> Dentures <input type="checkbox"/> Changes in Taste <input type="checkbox"/> Speech Problems <input type="checkbox"/> Bite/Chewing Changes <input type="checkbox"/> Dryness	<input type="checkbox"/> Cold Sores and/or Canker Sores <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Sore Throat/Sidedness <input type="checkbox"/> Dental Changes <input type="checkbox"/> Dental Decay <input type="checkbox"/> Metal Taste in Mouth	<input type="checkbox"/> Jaw Pain / TMJ Problems <input type="checkbox"/> Gagging <input type="checkbox"/> Tongue Tied <input type="checkbox"/> Hoarseness <input type="checkbox"/> Gum Troubles <input type="checkbox"/> Normal
7.	Neck	<input type="checkbox"/> Masses <input type="checkbox"/> Swelling <input type="checkbox"/> Enlarged Glands <input type="checkbox"/> Muscle Spasm	<input type="checkbox"/> Stiffness <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Pain <input type="checkbox"/> Range of Motion Changes <input type="checkbox"/> Skin/Temperature Changes <input type="checkbox"/> Normal
8.	Lungs	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Inhalation Pain <input type="checkbox"/> Exhalation Pain	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Coughing Up Sputum <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Difficulty Breathing Lying Down	<input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest Pain/Chest Tightness <input type="checkbox"/> Normal
9.	Vascular	<input type="checkbox"/> Pain Over Heart <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Slow/Fast Heart Beats <input type="checkbox"/> Arm/Leg Ache/Heaviness	<input type="checkbox"/> Swelling in Hands/Legs <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Calf Pain <input type="checkbox"/> Toe Temperature Changes <input type="checkbox"/> Finger Temperature Changes <input type="checkbox"/> Vascular Injuries	<input type="checkbox"/> Skin Color Change Legs/Feet/Hand <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Varicose Veins/Spider Veins <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Nail Bed Changes <input type="checkbox"/> Normal
10.	Gastro-Intestinal	<input type="checkbox"/> Blood in Stool <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Bowel Movement <input type="checkbox"/> Distension of Abdomen <input type="checkbox"/> Falling/Dropped Bladders	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Vomiting of Blood <input type="checkbox"/> Difficult Digestion/Food Sensitivities <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Dropping Reproductive System	<input type="checkbox"/> Heartburn <input type="checkbox"/> Gas or Belching <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Indigestion <input type="checkbox"/> Liver/Gallbladder History <input type="checkbox"/> Normal
11.	Genito-Urinary	<input type="checkbox"/> Sexual Dysfunction/Problems <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Pus in Urine <input type="checkbox"/> Bed-Wetting <input type="checkbox"/> Color: Dark Light Clear	<input type="checkbox"/> Increased Urination <input type="checkbox"/> Decreased Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Foul odor of Urine <input type="checkbox"/> Difficulty with Urination <input type="checkbox"/> Urinary Tract Infections (UTI) <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Normal
12.	Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hair loss <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Body Odors	<input type="checkbox"/> Warts <input type="checkbox"/> Brittle Nails <input type="checkbox"/> Changes in Moles <input type="checkbox"/> Temperature/Pain Changes <input type="checkbox"/> Fever Blisters/Herpes Lesions <input type="checkbox"/> Pimples/Acne	<input type="checkbox"/> Itching <input type="checkbox"/> Healing Time <input type="checkbox"/> Boils <input type="checkbox"/> Hives <input type="checkbox"/> Ulcers <input type="checkbox"/> Normal
13.	Neurology	<input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Strokes <input type="checkbox"/> Tremors <input type="checkbox"/> Running into Things <input type="checkbox"/> Muscle Twitches	<input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Numbness Sensation <input type="checkbox"/> Burning Sensation <input type="checkbox"/> Tripping Over Feet <input type="checkbox"/> Balance Problems	<input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Fainting <input type="checkbox"/> Spinning/Dizziness <input type="checkbox"/> Normal

Patient: _____

Date: _____

14.	Musculo-Skeletal	<input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Joint Popping/Moving <input type="checkbox"/> Bursitis <input type="checkbox"/> Sciatica: To Knee or Past Knee	<input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Anomaly/Deformities <input type="checkbox"/> Bone Pain <input type="checkbox"/> Bone Disease <input type="checkbox"/> Muscle Spasm/Cramp/Weakness/Achy	<input type="checkbox"/> Fractures <input type="checkbox"/> Dislocations <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Muscle Infection/Disease <input type="checkbox"/> Normal
15.	Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Concentration <input type="checkbox"/> Stress <input type="checkbox"/> Memory: Short Long	<input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Personality Changes <input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Anxiety <input type="checkbox"/> Phobias <input type="checkbox"/> Aggressive Behavior/Tendencies <input type="checkbox"/> Normal
16.	Social History	<input type="checkbox"/> Consume Alcohol <input type="checkbox"/> Smoker Past or Present <input type="checkbox"/> Stress Management <input type="checkbox"/> Social Drugs	<input type="checkbox"/> Exercise Regularly <input type="checkbox"/> Consume Coffee <input type="checkbox"/> Stress Level 1- 10: <input type="checkbox"/> Hobbies	<input type="checkbox"/> Consume Teas <input type="checkbox"/> Consume Soft Drinks <input type="checkbox"/> Nervous Habits <input type="checkbox"/> Normal
17.	Female ONLY OB-GYN	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Pregnancy # _____ <input type="checkbox"/> Age period began: <input type="checkbox"/> Discharge from Nipple <input type="checkbox"/> Cholesterol History	<input type="checkbox"/> PMS <input type="checkbox"/> Last PAP date: <input type="checkbox"/> Breast Exam date: <input type="checkbox"/> Mastectomy <input type="checkbox"/> Iron Deficiency	<input type="checkbox"/> Lumps in Breast <input type="checkbox"/> Are You Pregnant Yes No <input type="checkbox"/> Due Date: <input type="checkbox"/> Dr. Name & Number: <input type="checkbox"/> Normal
18.	Male ONLY	<input type="checkbox"/> Last PSA Test <input type="checkbox"/> History of Prostate	<input type="checkbox"/> Hernia History/Surgeries <input type="checkbox"/> Cholesterol History	<input type="checkbox"/> Genetic History <input type="checkbox"/> Normal

I have completed the above survey to the best of my ability.

Signature: _____

Date: _____

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

TREATMENT AUTHORIZATION RECORD

Consent for Release of Information & Patient Notification Statement

I, _____, hereby authorize Dr. Shaar, and/or her employees, to release to employer groups, insurance companies, government agencies or other third party payers, and their agents, information concerning health care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility, available benefits and obtaining payment on the behalf, for the Chiropractic health care provided to me. This authorization may be revoked in writing at any time, however, revocation will not apply to the previous dates of service. I understand that the care and service I will receive are subject to review by health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all charges incurred for my treatment if I revoke or refuse to authorize the disclosure of my medical records to a third party payer, and payment denial of my insurance claims results.

Patient/Guardian Signature _____ Date: _____

CANCELLED OR NO SHOW APPOINTMENTS

All appointments that are cancelled with **less than a 24 hour prior** notice will be subjected to a **\$25.00 fee** for that appointment time slot. An appointment that a **patient fails to show** will be **charged in full**. Payment will be required at the following scheduled appointment.

Initial _____

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

TERMS OF ACCEPTANCE

Thank you for asking us to support you on your way to optimum health. Cooperation and compliance from both the patient and the doctor will give us the best probability of success of a conservative health care program of a non-drug/surgery approach. This form of teamwork can only be positive when both parties give their honest effort towards the same goal. We at Shaar Chiropractic Health Care are giving our word to do our part of this teamwork goal for the most optimum level of health for you.

Here are some of the quality of life improvements that you will be asked to implement and/or add into your activities of living:

- Attending scheduled appointments, or re-scheduling when necessary.
- Communicating with the office and/or the doctor when necessary.
- Getting quality sleep.
- Increasing water intake.
- Practicing breathing and doing appropriate exercises when necessary.
- Doing an exercise/stress management program.
- Doing prescribed exercises.
- Decreasing junk food snacks.
- Decreasing sugar, soda and caffeine intake.
- Stopping ALL intake of nutra-Sweet and sugar substitutes.
- INCREASING TIME LAUGHING, FRIENDS/FAMILY AND QUALITY OF RELATIONSHIPS!!

Please sign below if you are in agreement to do your part in this goal of optimum level of health care.

Patient/Guardian Signature _____ Date: _____

Doctor Signature _____ Date: _____

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

OFFICE FINANCIAL POLICIES

To prevent any misunderstandings about your insurance coverage and our billing/collections procedures, we like to inform our patients that we can not render services on the ASSUMPTION that the patient care given will be paid for by an insurance company. You will be fully responsible for all professional services furnished that your insurance company does not pay.

For certain insurance plans that we do not participate in, we do reserve the right to NOT bill your insurance company. We will provide you with a receipt so you can submit your own bills.

It is our Office Policy to:

1. To collect full payment for cash patients the day services are rendered. If payment is not collected on day of service the cash discount will no longer apply and you will be billed our full standard fee.
2. Collection of deductibles payments and/or co-pays is done at the time of services rendered.
3. We will accept your insurance office visit co-pay as our in-office co-pay after each treatment, when deductibles have been met, in all cases. If your insurance company does not have a designated co-pay our in-office co-pay is \$25.00.
4. If your insurance company payment plus your in-office co-pay does not meet Shaar Chiropractic discounted cash rate patient will be responsible and billed for the difference plus 15% for insurance billing processing fee.
5. You will be charged a late fee of 21% APR, if payment is not received by the due date on the statement.
6. To collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are prescribed.
7. We will charge a \$35.00 fee for any returned checks.
8. Phone consultations over 10 minutes have a charge of \$35.00 per 15 minutes.
9. If your major medical insurance policy is a split percentage, ___%/ ___, we will set a payment to be collected at the time of service that will go towards your deductible. In doing this, we agree to write off any balance (except nutritional supplies, supports, treatment instruments, pillows/wedges or deductibles) not covered by your insurance company. If however, you do not pay this set fee at the time of service, we will bill you for the full percentage as stated in your policy.
10. Patients who have Blue Cross/Blue Shield (BC/BS) out of state insurance **please be advised** that you will receive a check from your insurance company in the mail. This check will be in your name however this check is not for you. This is our check and needs to be signed over to Shaar Chiropractic. We are not contracted, in-network with BC/BS and therefore they will pay the patient for the services we have provided. Failure to turn over the check and pay us for the services we have provided will result in the file going to collections.

Your signature will signify your understanding and compliance with our policies. Thank you.

PATIENT SIGNATURE: _____ Date: _____

Directions to Shaar Chiropractic & Neurology, P.C.

at Wells Fargo Bank Building
10288 W. Chatfield Ave., Suite 305
Littleton, CO. 80127
303-980-3009

From the North or West:

- **South** C-470 (travel towards DTC).
- Exit Ken Caryl Ave. go **East** (left).
- (go under over pass of C-470)
- (go through 4 lights)
- Turn **Right** (south) at 5th light onto W. Chatfield Ave.
- (go through 2 lights)
- Turn **Right** (south) at 3rd light onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

From Downtown:

- **South** on Sante Fe.
- (look for Aspen Grove on the right and Light Rail walking bridge above Santa Fe)
- Turn **Right** (west) at the light onto Mineral Ave **OR** continue straight to C-470 and follow the South or East directions (below) heading West on C-470.
- (go through 2 lights)
- Turn **Left** (south) at 3rd light onto Platte Canyon Rd.
- (go through 6 lights)
- Turn **Left** (south) at the 7th light onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

From the South or East:

- **West** on C-470 (traveling towards the mountains).
- Exit Kipling Pkwy go **North** (right).
- (go through 2 lights)
- Turn **Left** (west) at 3rd light onto Chatfield Ave.
- Turn **Left** (south) from the second left turn lane onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

AFTER HOURS ACCESS:

Please use the silver box on the west side entrance to the Wells Fargo Bank Building. Pick up the phone, scrolling through the directory, find our name and calling our office. Through this process we can allow you access.