325 FOURTH ST MARIETTA, OH 45750

740.376.9944
INFO@MYMARIETTAHEALTH.COM

NEW PATIENT REGISTRATION

Today's Date: ___________ Primary Care Physician:______________________

Name: Last______________________First:______________________Middle: ___________ Marital Status: Single/ Mar/ Div / Sep/ Widow

Date of Birth:________________Sex:___________ Social Security Number: ___________

Street Address: ______________________________City:________________State:___________Zip:___________

Primary Phone:________________ Email:______________________________

Occupation: ______________________________Employer: _______________Work Phone: _______________

How did you learn about us? ______________________________

Emergency contact: ______________________________ Relation:_______________Phone Number:_______________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MHWC or insurance company to release any information required to process my claims.

Patient/ Guardian Signature: ______________________________ Date: _______________

Please scan the QR code below to create your online patient account.

What You Can Do On Your Online Account:

- View Statements/ See your Balance
- Get any Receipts from Payments
- Make Payments on your Balance
- See ALL your upcoming Appointments

MHWC

Are you experiencing any of the following symptoms? (CHECK ALL THAT APPLY)

- ☐ Fatigue
- ☐ Nosebleeds
- ☐ Swelling
- ☐ Blood in Stool
- ☐ Rashes
- ☐ Hot Flashes
- ☐ Ringing in Ears
- ☐ Weight Changes
- ☐ Nasal Congestion
- ☐ Cough
- ☐ Frequent Urination
- ☐ Skin Growths
- ☐ Seasonal Allergies
- ☐ Hoarseness
- ☐ Blurred Vision
- ☐ Chest Pain
- ☐ Urinary Burning
- ☐ Passing Out
- ☐ Anxiety
- ☐ Vomiting
- ☐ Eye Drainage
- ☐ Dizziness
- ☐ Diarrhea
- ☐ Joint Pain
- ☐ Headaches
- ☐ Depression
- ☐ Back Pain
- ☐ Earache
- ☐ Sore Throat
- ☐ Nausea
- ☐ Muscle Pain
- ☐ Swollen Glands
- ☐ Difficulty Sleeping
- ☐ Heat/Cold Intolerances

Have you ever been diagnosed with the following? (CHECK ALL THAT APPLY)

- ☐ Hypertension
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ GERD
- ☐ Gallbladder Disease
- ☐ Liver Disease
- ☐ Anemia
- ☐ Allergies
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Serious Injury
- ☐ Ear Problem
- ☐ Eye Problem
- ☐ Skin Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ ADHD
- ☐ Tuberculosis
- ☐ Mononucleosis
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Eye Problem
- ☐ Skin Disease
- ☐ Genital Herpes
- ☐ Other_______________

Family History (CHECK ALL THAT APPLY)

- ☐ No know family history
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Gallbladder
- ☐ Cancer ______________
- ☐ Liver Disease
- ☐ Peptic Ulcers
- ☐ Kidney Disease
- ☐ Alzheimer's
- ☐ Stroke
- ☐ Migraines
- ☐ Seizure Disorder
- ☐ Mental Illness _________
- ☐ Glaucoma
- ☐ Skin Disease
- ☐ Allergies
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Anemia
- ☐ Diabetes

Do you now or have you ever?

Smoked? ☐ Yes ☐ No Packs a Day:_________ No. of Years__________

Exposed to Smoke? ☐ Yes ☐ No

Drank Alcohol? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never

Drank Caffeine? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never

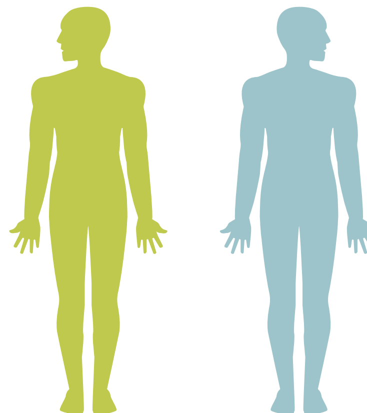
Use Illegal Drugs? ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No Days a Week:________________

MHWC

Reason for Visit:________________________________ When did your symptoms appear? ____________________

Is the condition progressivly getting worse? ☐ Yes ☐ No



Mark an X where you have pain, numbness, tingling

Rate severity of your pain on a scale of 1-10: ______

Type of Pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness
☐ Aching ☐ Swelling ☐ Shooting ☐ Other

How often do you have this pain?________________________________

Is it constant or come and go? ________________________________

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

For Women

Last Menstrual Cycle:____________ Age Period Began:____ Problems with cycle:________________
Birth Control:_____________ Date of last PAP:__________ No. of Pregnancies:_________
Problems with Pregnancies:_____________ Date of last Mammogram: __________ Age at Menopause:______

Please list all Surgeries and/or Hospitalizations

Surgery	Surgeon	Year	Hospitalization	Year

Please List all Medications you are currently taking

Name of Medication	Dose	How Often	Purpose

Any medication Allergies?_____________________________________

Are your immunizations current?_____________________________________

Have you had a Tetanus shot in last 10 years? If so, when?_____________________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services
- We may need to use your health information within our practice as quality control or other operational pur cont.

We may have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on this use or disclosure of your health information, please let us know.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we already release your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information. You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical treatment.
- The right to see and copy your protected health information.
- The right to receive confidential communications about your medical condition and treatment.
- The right to amend or make corrections to your personal health information.
- The right to receive an accounting disclosure of your personal health information.
- The right to receive a paper copy of our privacy notice.

NOTICE OF PRIVACY PRACTICES

REQUESTS TO INSPECT PERSONAL AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date the record was created.We require your request to inspect and/or copy your health information be in writing.

YOUR RIGHT TO COMPLAIN

You may complain to us if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:
Jeffrey R. Dexter, DC | Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750

OUR DUTIES

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply to all of your health information.

TO CONTACT US

If you would like further information about our privacy policies and practices please contact:
Jeffrey R. Dexter, DC I Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750 / 740-376-9944

TO THE PATIENT

This notice is in effect as of March 13, 2007. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

______________________________	______________________________	__________
Patient Name (please print)	*Patient Signature*	*Date*

____
Signature of parent or legal guardian

INFORMED CONSENT

Doctor-Patient relationship in Chiropractic

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes,_physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. 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 health care, if he/she is aware that such care may be contraindicated. Again, 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, non-duplicating 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.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic, in turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems, both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.
I have read, and understand the foregoing.

______________________	______________________	__________
Patient Name (please print)	*Patient Signature*	*Date*

____
Signature of parent or legal guardian

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Jeffrey R. Dexter, DC, and/or his staff to examine and /or treat my daughter/son.

____
Full Name of Child (please print)

______________________________ ______________________ __________ __________
Street Address *City* *State* *Zip*

____
Phone Number

SIGNED

______________________________ __________________________ ____________
Name of Parent or Legal Guardian *Signature* *Date*

WITNESS

______________________________ __________________________ ____________
Name (please print) *Signature* *Date*