COMBINED CARE CENTER, P.C.
283 Peterson Rd., Libertyville, Il. 60048 847-367-1770
www.combinedcarecenter.com

PATIENT REGISTRATION

NAME: _____ (Please Print Full Name)

DATE OF BIRTH: _____ TODAY'S DATE: _____

ADDRESS: _____
Street no. City State Zip

MARITAL STATUS: S M D W SOCIAL SECURITY NO. _____

PHONE: Home- _____ Work- _____ Cell- _____

EMAIL: _____

EMPLOYER: _____ PHONE: _____

WORK ADDRESS: _____

SPOUSE'S NAME: _____ PHONE: _____

OTHER CONTACT: _____ PHONE: _____

THIS VISIT IS THE RESULT OF: Auto Accident ☐ Work Injury ☐ Other ☐

INSURANCE INFORMATION

NAME OF COMPANY: _____

NAME OF INSURED: _____ D.O.B. _____

EMPLOYER OF INSURED: _____

Authorization to release information: To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my record to my insurance company.
Assignment: I authorize my insurance benefits to be paid directly to the physician when he is filing on my behalf and I am financially responsible for any non-covered service, deductible, co-pay, etc. This assignment will remain in effect until I revoke it in writing.

Signature: _____

☐ To be signed in our office

COMBINED CARE CENTER, P.C.
Dan M. Young, D.C., D.N., D.A.B.C.O.
Diplomate of the American Board of Chiropractic Orthopedics
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REVIEW OF SYSTEMS:

Patient- _____ Date- _____

Please tell us if any conditions below apply. Other- _____
(Add details if affirmative)

Takes anticoagulants: _____ ◯ Yes ◯ No

Has a pacemaker: _____ ◯ Yes ◯ No

Has osteoporosis: _____ ◯ Yes ◯ No

Has diabetes: _____ ◯ Yes ◯ No

Has a herniated disc: _____ ◯ Yes ◯ No

Has cancer: _____ ◯ Yes ◯ No

Had cancer: _____ ◯ Yes ◯ No

Bruises easily: _____ ◯ Yes ◯ No

Has high blood pressure: _____ ◯ Yes ◯ No

Has a heart condition: _____ ◯ Yes ◯ No

Is pregnant: _____ ◯ Yes ◯ No

Has known allergies: _____ ◯ Yes ◯ No

Other: _____

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Past Medical History

Name: _____ Date of birth: _____ Sex: _____

Date: _____

List all sugeries and their dates:

List current medications: For what condition:

List any severe injuries and dates:

List x-ray/MRI and dates:

List any diseases you have or have had:

List conditions which run in your family:

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Combined Care Center

HISTORY OF PRESENT ILLNESS

283 Peterson Road
Libertyville, Il 60048

Dan M. Young, D.C., D.N., D.A.B.C.O.

Patient: _____

Date: _____

Chief Complaint: What is the body area? _____

: When did it start? _____

: What circumstances caused it? _____

: Have you had it before/ When? _____

: What relieves it? _____

: What worsens it? _____

: Does it include radiating to other areas? Yes ◯ No ◯

: How would you describe it, examples, BURNING, STABBING, DULL, SHARP, NUMB, CRAMPING, TINGLING

_____

: Worse in AM ◯ or PM ◯ : Constant ◯ or Intermittent ◯

Second Complaint:

: What is the body area? _____

: When did it start? _____

: What circumstances caused it?

OTHER: Please give any information you think is relevent to the two complaints above:

Give other information relevent in the space below:

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HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and discuss my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day health care operation of your practice

I have also been informed of and give the right to review and secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to that date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____