BABBITT CHIROPRACTIC CENTER, LLC
DR. GRANT L. BABBITT

120 SOUTH MARTINE AVENUE
FANWOOD, NJ 07023
TELEPHONE 908-680-9600
FAX 908-680-9601

PATIENT REGISTRATION

WELCOME TO OUR OFFICE!! PLEASE PRINT AND ANSWER ALL QUESTIONS.

TODAY'S DATE: _____

NAME:_____ SEX: M F DATE OF BIRTH_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HEIGHT:_____ WEIGHT:_____ MARITAL STATUS: M S D W

SPOUSE NAME:_____

SOCIAL SECURITY#_____ PHONE#:_____

OCCUPATION:_____ CELL PH#:_____

IF YOU WOULD LIKE REMINDERS TEXTED TO YOUR CELL PHONE#, CHECK THIS BOX ☐

COMPANY NAME:_____ BUSINESS PH#:_____

COMPANY LOCATION:_____

HOW DID YOU HEAR ABOUT US?_____

PLEASE DESCRIBE THE HEALTH PROBLEMS AND SYMPTOMS FOR WHICH YOU CAME HERE:

_____

WHEN DID YOUR SYMPTOMS FIRST APPEAR?_____

HAVE YOU HAD THIS PROBLEM FOR LONG?_____

LIST ANY DOCTORS YOU HAVE SEEN FOR THIS:_____

LIST ANY DIAGNOSIS/TREATMENTS FOR THIS:_____

_____

HAVE YOU HAD ANY RECENT X-RAYS TAKEN OF THIS AREA FOR PAIN?_____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE BEFORE?_____

_____

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HEALTH HISTORY

Please circle those illnesses which have affected you and specify the nature of the condition.

Cardiovascular	Heart Attack	High Blood Pressure	High Cholesterol		
Neurological	Seizures	Multiple Sclerosis	Parkinson's Disease	Stroke	Other
Pulmonary	Emphysema	Bronchitis	Asthma	Other	
Endocrine	Diabetes	Thyroid Disease	Other		
Infectious Disease		HIV	Hepatitis	Other	
Gastrointestinal		Ulcer	Chron's	Other	
Oncologic	Cancer				
Hematologic	Anemia	Sickle Cell	Other		
Auto Immune	Lupus	Celiac	Other		
Skeletal	Fractures	Osteoporosis	Knee/Hip Replacement		Other

Any other medical condition (s) that you want the doctor to be aware of: _____

_____

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing of payment of medical claims. I authorize payment of medical benefits of the provider.

I acknowledge the practice's adherence to the Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 and may request a personal copy at any time.

Signature_____ Date:_____

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HIPPA POLICY

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits the Doctor or our staff from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members of caretakers to obtain information for them.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.

Name of Individual_____ Relationship to Patient_____

Name of Individual_____ Relationship to Patient_____

Only these individuals will be provided with information. Should you wish to update the names provided below, please ask at the front desk and your records will be updated accordingly.

SIGNATURE_____ TODAY'S DATE:_____

Patient Release – Must be signed by patient if over 18 or by legal guardian of patient if under 18