NEW YORK CHIROPRACTIC COLLEGE NEW PATIENT REGISTRATION

Seneca Falls Health Center – Rochester Health Center- Levittown Health Center- Depew Health Center- Campus Health Center

Welcome to our Health Center! Your Health History is important to us. Please fill out this form COMPLETELY.					
Today's Date:					
Patient Title: ☐Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.					
Last Name					
First Name	Middle Initial				
Address					
City		State		Zip	
Primary Phone ( )		Mobile Phone ( )			
Email:					
Date of Birth: / /	Age	Sex: ☐ Male ☐Female ☐Other			
Marital Status: (Check One) ☐ Single ☐ Married ☐ Other					
Emergency Contact:		Phone: ( )			
Primary Care Provider:		Phone: ( )			
Primary Care Provider Address:					
☐ Please do not share the results of this visit with this provider					
Race: Please Check One					
☐ White	☐ Black/African American	☐ American Indian/Alaskan Native	☐ Asian		
☐ Native Hawaiian/other Pacific Island		☐ Other	☐ Choose not to Specify		
Ethnicity: Please Check One					
☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Choose not to Specify			
Preferred Language: Please Check One					
☐ English	☐ Spanish	☐ Chinese	☐ French	☐ Tagalog	☐ American Sign Language
☐ Other				☐ Choose not to Specify	

Are you the patient, or are you completing this for the patient?
☐ I am the patient. ☐ I am completing this for the patient. Is the patient a minor? ☐ Yes ☐ No
If you are completing this form for the patient, please enter your name:

Employment Status: Please Check One					
☐ Employed Full Time	☐ Employed Part-time	☐ FT Student	☐ PT Student		
☐ Retired	☐ Self-Employed	☐ Other			
Employer Name		Address			
City		State		ZIP	
Employer Phone: ( )		Position/Occupation			
Please Continue on the Reverse					

Patient Name:	
Insurance Information	
Subscriber's Name	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	
Is Patient covered by additional insurance? ☐ Yes ☐ No	
If Yes, Subscriber's Name:	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	

Please tell us how you heard about us:	
☐ Physician Referral (Please indicate Name)	
☐ Personal Referral (Please indicate Name)	
☐Phone Book ☐ Internet Search ☐ Other (Please Specify)	
☐ Yes **☐ No**	**Permission to Contact: I grant permission to be called to confirm or reschedule my appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.**
Please review the following statements and sign on the last line indicating your agreement:	
<u>Payment Verification</u>: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive	
<u>General Verification</u>: To the best of my ability, the information I have supplied today is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.	
Patient Signature:	**Date:**
Please Continue to the Next Page	

New Patient Information	Date:
Patient Name:	
CURRENT MEDICATIONS: Please list all prescriptions, over-the-counter medicines and supplements) including frequency and dosage (if known). If there are NO current medications, check here ☐	
1.	2.
3.	4.
5.	6.
7.	8.
Please list any ALLERGIES you have to medications. If NO known allergies, check here ☐	
1.	2.
3.	4.
Do you use tobacco of any type? ☐ Yes ☐ No ☐ Former Tobacco User ☐ Never Used Tobacco	
If Yes, how often do you use tobacco? ☐ Current every day user ☐ Current sometimes user	
If you are a tobacco user, what is your interest in quitting on a scale where 0 is "No Interest" and 10 is "Very Interested"?	

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Do you presently have a diagnosis of Hypertension?	☐ Yes ☐ No
Do you presently have a diagnosis of Diabetes? ☐	☐ Yes ☐ No
If "Yes" to Diabetes, what kind?	☐ Type I ☐ Type II
If "Yes" to Diabetes, do you know your A1C level?	☐ Yes ☐ No ☐ Not Sure
Comments regarding your Diabetes diagnosis:	
YOUR SYMPTOMS TODAY	
Please describe your symptoms:	
When did your symptoms start? Month Day Year	
How did your symptoms begin?	
Please indicate the location and severity of your symptoms on the Pain Diagram given to you today	
How often do you experience your symptoms?	
Do your symptoms affect other areas of your body? To what extent does the pain radiate, shoot or travel?	
What makes your pain better or worse? (Certain movements, activities, positions, etc.) Better:	
Worse:	
What time of day do you experience your symptoms? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night	
Prior Interventions: What have you done to relieve the symptoms? Please Check all that apply	

☐ Prescription Medicine	☐ Acupuncture	☐ Over the Counter Medication	☐ Ice
☐ Homeopathic Remedies	☐ Chiropractic	☐ Physical Therapy	☐ Heat
☐ Massage	☐ Other		

Please Continue on the Reverse

New Patient Information	Date:
Patient Name:	

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident or Injury:

Have you reported this accident to:

☐ Auto Insurance ☐ Employer ☐ Workers' Comp. ☐ Other ☐ Not Reported

Is there anything else we should know about your condition?

Please check the boxes if you HAVE or HAD any of the listed conditions

	Musculoskeletal		Cardiovascular		Endocrine		Respiratory
☐	No Issues	☐	No Issues	☐	No Issues	☐	No Issues
☐	Osteoporosis	☐	High Blood Pressure	☐	Thyroid Issues	☐	Asthma
☐	Arthritis	☐	Low Blood Pressure	☐	Immune Disorders	☐	Apnea
☐	Scoliosis	☐	High Cholesterol	☐	Hypoglycemia	☐	Emphysema
☐	Neck Pain	☐	Poor Circulation	☐	Frequent Infection	☐	Hay Fever
☐	Back Problems	☐	Angina	☐	Swollen Glands	☐	Shortness of Breath
☐	Hip Disorders	☐	Excessive Bruising	☐	Low Energy	☐	Pneumonia
☐	Knee Injuries	☐	Other	☐	Other	☐	Other
☐	Elbow/Wrist Pain						
☐	TMJ Issues		**Digestive**		**Genitourinary**		**Integumentary**
☐	Foot/ankle Pain	☐	No Issues	☐	No Issues	☐	No Issues
☐	Poor Posture	☐	Anorexia/Bulimia	☐	Kidney Stones	☐	Skin Cancer
☐	Shoulder Problems	☐	Ulcer	☐	Infertility	☐	Psoriasis
☐	Other	☐	Food sensitivities	☐	Bedwetting	☐	Eczema
	Neurological	☐	Heartburn	☐	Prostate Issues	☐	Acne
☐	No Issues	☐	Constipation	☐	Erectile Dysfunction	☐	Swollen Glands
☐	Anxiety	☐	Diarrhea	☐	PMS Symptoms	☐	Rash
☐	Depression	☐	Other	☐	Other	☐	Other
☐	Headache		**Sensory**		**Constitutional**		
☐	Dizziness	☐	No Issues	☐	No Issues		
☐	Pins and Needles	☐	Blurred Vision	☐	Fainting		
☐	Numbness	☐	Ringing in Ears	☐	Low Libido		
☐	Other	☐	Hearing Loss	☐	Poor Appetite		
		☐	Loss of Smell	☐	Fatigue		
		☐	Loss of taste	☐	Erectile Dysfunction		
		☐	Chronic Ear Infection	☐	Weakness		
		☐	Other	☐	Other		

Please explain any items you checked above:

ITEM	EXPLANATION

Please Continue to the Next Page

New Patient Information	Date:

Patient Name:

Are there any past or current medical conditions you have not told us about?

Please list date(s) and reason(s) for any hospitalizations:

Date	Reason	Date	Reason

Please list any surgical procedures you have had:

Date	Procedure	Date	Procedure

Please list any other injuries not described above:

Date	Injury	Date	Injury

Family History

Relative	Health Condition or Illness
Mother	
Father	
Brother(s)	
Sister(s)	
Son(s)	
Daughter(s)	
Other	

Stress Information

On a scale of 0 to 10, where 0 means you have NO stress and 10 means a LOT OF STRESS, please indicate your PHYSICAL stress level:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

On a scale of 0 to 10, where 0 means you have NO stress and 10 means a lot of stress, please indicate your EMOTIONAL stress level:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What are the major stressors in your life:

Please Continue on the Reverse

New Patient Information	Date:
Patient Name:	
Consumption, Sleeping , and Exercise Information	
How much alcohol do you consume?	Frequency?
How many cups of coffee do you drink daily?	
How much soda pop do you consume daily?	
How much water do you drink daily?	
Do you use recreational drugs? ☐ Yes ☐ No	

Please rate your eating habits where 0 means your eating habits are UNHEALTHY and 10 means your eating habits are HEALTHY:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What are your typical eating habits:

☐ Skip Breakfast	☐ 2 Meals per Day	☐ 3 Meals per Day	☐ Snacking Between Meals

On average, how many hours do you sleep at night?	
What is your preferred sleeping position?	
On a regular basis, how much do you exercise?	

What would be the most significant thing you could do to improve your health?

What additional health goals do you have?

Patient Signature:

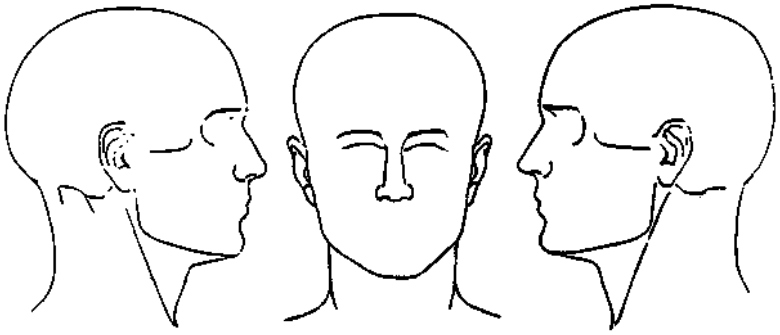
Pain Diagram

Patient's Name: _____

NEW YORK CHIROPRACTIC COLLEGE

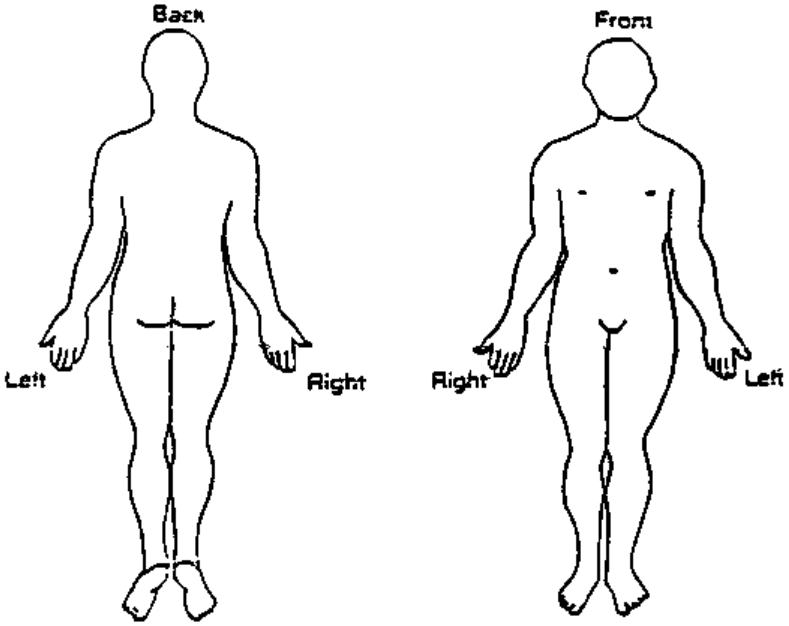
Draw the location of your pain on body outlines and mark how bad it is on pain line at bottom of page.
Indicate location and the type of pain using the following chart:

1 – Ache	2 – Burning	3 – Numbness
4 – Pins and Needles	5 – Stabbing	6 – Other



No Pain ——————————— Worst Pain Possible

Please make a slash through this line as to the level of your pain



No Pain ——————————— Worst Pain Possible

Please make a slash through this line as to the level of your pain

Patient's Signature	Date:

NEW YORK CHIROPRACTIC COLLEGE
Notice of Patient Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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.

Your Rights:
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
- **You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.**
- **We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.**

Ask us to correct your medical record:
- **You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.**
- **We may say "no" to your request, but we'll tell you why in writing within 60 days.**

Request confidential communications:
- **You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.**
- **We will say "yes" to all reasonable requests.**

Ask to limit what we use or share:
- **You can ask us not to use or share certain health information for treatment, payment, or our operations.**
- **We may not be required to agree to your request, and we may say "no" if it would affect your care.**
- **If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.**
- **We will say "yes" unless a law requires us to share that information.**

Get a list of those with whom we've shared information:
- **You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.**
- **We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.**

Get a copy of this privacy notice:
- **You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.**

Choose someone to act for you:
- **If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.**
- **We will make sure that person has this authority and can act for you before we take any action.**

File a complaint if you feel your rights are violated:
- **You can complain if you feel we have violated your rights by contacting us using the information on the back page.**
- **You can file a complaint with the U.S. Department of Health and Human Services Offices for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**
- **We will not retaliate against you for filing a complaint.**

Your Choices:
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- **Share information with your family, close friends, or others in your care.**
- **Share information in a disaster relief situation.**

If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:
- **Marketing purposes.**
- **Sale of your information.**
- **Most sharing of psychotherapy notes.**

Effective: October 2, 2017

In the case of fundraising:

- **We may contact you for fundraising efforts, but you can tell us not to contact you again.**

Our Uses and Disclosures

We typically use or share your health information to:

Treat you. We can use your health information and share it with other professionals who are treating you. ***Example: A doctor treating you for an injury asks another doctor about your overall health condition.***

Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example: We use health information about you to manage your treatment and services.***

Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. ***Example: We give information about you to your health insurance plan so it will pay for your services.***

How else can we use or share your health information?

We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues:

- **We can share health information about you for certain situations such as:**
  - **Preventing disease.**
  - **Helping with product recalls.**
  - **Reporting adverse reactions to medications.**
  - **Reporting suspected abuse, neglect, or domestic violence.**
  - **Preventing or reducing a serious threat to anyone's health or safety.**

Do research:

- **We can use or share your information for health research.**

Comply with the law:

- **We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.**

Respond to organ and tissue donation requests:

- **We can share health information about you with organ procurement organizations.**

Work with a medical examiner or funeral director:

- **We can share health information with a coroner, medical examiner, or funeral director when an individual dies.**

Address worker's compensation, law enforcement, and other government requests:

- **We can use or share health information about you:**
  - **For worker's compensation claims.**
  - **For law enforcement purposes or with a law enforcement official.**
  - **With health oversight agencies for activities authorized by law.**
  - **For special government functions such as military, national security, and presidential protective services.**

Respond to lawsuits and legal actions:

- **We can share health information about you in response to a court or administrative order, or in response to a subpoena.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice. We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practice applies to the following New York Chiropractic College's Health Centers:

Depew Health Center 4974 Transit Rd. Depew, NY 14043,
http://www.depewhealthcenter.com/
Levittown Health Center 70 Division Ave. Levittown, NY 11756,
http://www.levittownhealthcenter.com/
Rochester Health Center 1200 Jefferson Rd. Rochester, NY 14623,
http://www.rochesterhealthcenter.com/
Seneca Falls Health Center 2360 State Route 89 Seneca Falls, NY 13148,
http://www.senecafallshealthcenter.com/
Campus Health Center
2360 State Route 89, Seneca Falls, NY 13148

Privacy Officer:
Wendy Maneri, Associate Dean of Chiropractic Clinical Education and Health Centers
wmaneri@nycc.edu
Phone: 315-568- 3262

NEW YORK CHIROPRACTIC COLLEGE HEALTH CENTERS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF NYCC'S PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of NYCC's Notice of Privacy Practices.

_____ _____

Patient Name Patient's DOB

_____ _____

Signature of Patient or Personal Representative* Date

*If signed by a Personal Representative, the following information must also be included:

_____

Name of Personal Representative

_____

Relationship of Personal Representative to Patient

For Administrative Use Only

I have made a good faith effort to obtain patient written acknowledgment but patient was unable/unwilling because:

Signature_____

Date_____

Effective: October 2, 2017