Welcome to our office!

1

ABOUT YOU

Date: ___/___/_____ Name:_____
[ ] Male [ ] Female Preferred Name: _____
Birthdate: ___/___/_____ Age: ___ SS# _____
Home Address: _____
_____
City State Zip
Home Phone #: _____Cell #: _____
Email Address: _____
Referred By: _____
Employer: _____How Long?_____
Employers Address: _____
Occupation: _____Work Phone: _____
Marital Status:
[ ]Single [ ] Married [ ] Divorced
[ ] Separated [ ] Widowed
Spouse's Name: _____
Spouse's Phone:_____
Medical Physician's Name: _____

2

INSURANCE INFORMATION

Co. Name: _____
Address: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Relationship: _____Date of Birth: __/__/___
Insured's Employer: _____

Please inform us of any Secondary Insurance Source

3

REASON FOR VISIT

Have you had previous Chiropractic Care? _____
What is your Major Complaint? _____
Other Complaints? _____
How did condition develop? _____
Date of Onset? _____
Have you had same or similar problems in past? [ ] Y [ ] N
Is this condition getting worse? [ ] Yes [ ] No
[ ] Constant [ ] Comes and goes
How long has it been since you really felt good?
_____
What aggravates condition? _____
Does anything offer relief? _____
How would you describe condition? [ ] sharp [ ] dull [ ] achey [ ] throbbing
What percent of time does this condition bother you?
[ ] 0% [ ] 25% [ ] 75% [ ] 100%
How would you rate the level of discomfort on a scale of 0-10? ___

4

ACCOUNT INFORMATION

(Person ultimately responsible for accounts information)

Name: _____
Relation: _____
Billing Address: _____
_____
S.S. #: _____
D.L. #: _____
Work Phone #: _____
Payment Method:
[ ] Cash [ ] Check [ ] Credit Card

CC #: _____
Expiration Date: ___/__/_____
CVV #: _____

[ ] I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered

HEALTH HISTORY

Are you taking any of the following medications?
[ ] Nerve Pills [ ] Pain Killers (including aspirin) [ ] Muscle Relaxers
[ ] Stimulants [ ] Blood Thinners [ ] Tranquilizers [ ] Insulin [ ] Other _____

Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack	Y N Heart Surgery/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/ AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/ Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/ Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Pain	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition (s) you have or ever had: _____
_____
Please list anything that you may be allergic to: _____
_____
List ALL previous surgeries/treatment with dates: _____
_____
List any and all accidents with dates: _____
_____

Do you smoke? [ ] No [ ] Yes/ How much? _____ How Long?_____

For Women:
Are you taking birth control? [ ] Yes [ ] No
Are you Pregnant? [ ] Yes [ ] No / How far along? _____ Nursing? [ ] Yes [ ] No

- We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- The doctor reserves the right to make any financial arrangements necessary to provide affordable care in the event of a hardship situation.
- I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in medical status.

Signature: _____ Date: _____

I authorize the staff to perform any necessary services needed during diagnoses and treatment on my minor child.

Signature: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date