

PATIENT PERSONAL/CONFIDENTIAL DATA

Date _____
Patient: _____ Date of Birth: ____/____/____ Age: ____
Gender: M__ F__ Marital Status: M__ S__ O__ Number of Children: ____ SSN: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Employer: _____
Name of Spouse: _____ D.O.B. ____/____/____ SSN: ____/____/____
Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Who is responsible for the payment? Self ____ Spouse ____ Other: _____
Family Doctor: _____ Phone Number: _____ Address: _____

Patient's Insurance:	Spouse's Insurance:
Name of Company: _____	Name of Company: _____
Address: _____	Address: _____
ID & Group #: _____	ID & Group #: _____
Phone: _____	Phone: _____

Purpose of this appointment and list your complaints:

Date when problem/ injury started? _____
Please describe the circumstances and what make the condition(s) better or worse:

Other Doctor seen for this condition: _____
Have you been treated by a doctor for any health conditions in the last year? Yes ____ No ____
If yes, Please describe: _____

Billing Information
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that all balances must be paid within 90 days. Any balances over 60 days will be charged a one and one half percent service charge per month unless prior arrangements for payment have been made. I also agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I agree to be held responsible for any returned check fee of \$30.

Patient Signature: _____ **Signature Physician:** _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, Chiropractor Care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part to the clinic charge, including and not limited to, hospital or medical service companies, insurance companies, workers compensation, welfare funds, or the patient's employer.

Patient Signature: _____ **Patient or Guardian Signature:** _____

Health Questionnaire

Please check mark each of the Conditions below that you are currently experiencing

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder Trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal Discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse

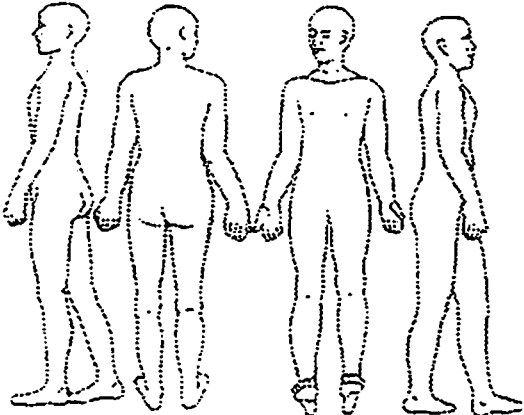
CARDIO-VASCULAR SYSTEM

- Chest pain
- Pain over heat
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficulty speech
- Sinus
- Allergy
- Jaw Pain

SYMPTOM LOCALIZATION



P Pain

N Numb

S Spasm

T Tender

H Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature: _____

.....DO NOT WRITE BELOW THIS LINE.....

Patient Accepted Yes No Doctor's Signature _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

THIS NOTICE DESCRIBES HOW HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Patient Name: _____ **D.O.B:** _____

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1) Your personal health information (PHI), including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2) Your health records, as well as your billing records may be disclosed to another party, such as an insurance carrier (HMO, PPO, Automatic insurance, etc.) or your employer (if they are responsible for payment).

3) Your name, address, phone number and your health records may be used to contact you regarding appointment reminders or provide information about alternatives to your present care. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. You may also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are permitted to use or disclose your PHI without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. *By signing below, I acknowledge that I have read the above information and give full disclosure of my information.*

Patient/Guardian Signature: _____ **Date:** _____

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. I agree to be held responsible for any returned check at a fee of \$30.00.

Patient/Guardian Signature: _____ **Date:** _____

Consent of Professional Services

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature: _____ **Date:** _____