CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION:

NAME: ____TODAY'S DATE: __________________________

HOW DID YOU HERE ABOUT US?
____ NEWSPAPER ___FRIEND ____RADIO___ BUS STOP BENCH AD
____MEDICAL DOCTOR REFERRAL ___ ATTORNEY REFERRAL ___OTHER_________

STREET: ____APT #:___________________________

CITY: ________________________________STATE:______________ZIP:_________________________

HOME PHONE: ____________________CELL PHONE: _______________PAGER:__________________

BIRTH DATE: ______________________ SOCIAL SECURITY NUMBER: ________________________

SEX: ___ Male ___Female MARITAL STATUS: ___Single ___Married ___Divorced

STUDENT STATUS: ___N/A ___ F/T ___ P/T *E-Mail Address*: _________________________________

EMPLOYER'S NAME: ___________________________OCCUPATION:__________________________

EMPLOYER CITY: _________________________STATE:_____________ ZIP: _____________________

EMPLOYER ADDRESS: ________________________________WORK PHONE: ____________________

SPOUSE'S\SIGNIFICANT OTHER'S NAME: ____

SPOUSE'S WORK PHONE: __________________________________

NAME AND PHONE OF NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU: _______________

PRESENT COMPLAINT:

PLEASE DESCRIBE YOUR SYMPTOM (S) BRIEFLY: 1. ____________________________________

2. ____3.______________________________________

4. ____5.______________________________________

ARE THESE SYMPTOMS DUE TO AN ACCIDENT: ___Yes ___No

IF YES, TYPE OF ACCIDENT: ___Auto ___Work ___ Other DATE OF ACCIDENT: _______________

PLEASE CHECK ANY AND ALL INSURANCE COVERAGE THAT MAY BE APPLICABLE IN THIS CASE.
π
Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident π

Other π Medical Savings Account & Flex Plans

NAME OF PRIMARY INSURANCE COMPANY____

NAME OF SECONDARY INSURANCE COMPANY (if any) ____

AUTO ACCIDENT:

ACCIDENT REPORTED: ___ No ___Yes ___Worker's Comp ___Insurance Carrier ___Employer

HAVE YOU RETAINED AN ATTORNEY FOR THIS ACCIDENT ___Yes ___ No

IF YES, ATTORNEY'S NAME AND PHONE NUMBER: ____

NAME OF INSURANCE COMPANY OF THE AT FAULT PERSON: ____________________________

NAME OF YOUR AUTOMOBILE INSURANCE: ____

NAME OF HEALTH INSURANCE: ____

MEDICAL HISTORY:

NAME, TELEPHONE NUMBER, AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN:

____

___ Anemia	___ Muscular Dystrophy	___Rheumatic Fever	___ High Blood Pressure	
___ Allergies	___ Cancer	___Polio	___ Multiple Sclerosis	
___ Scarlet Fever	___Tuberculosis	___HIV	___ Sinus Trouble	
___ Asthma	___German Measles	___Nervousness	___ Heart Trouble	
___ Numbness	___Convulsions	___Epilepsy	___ Concussion	___ Shingles
___ Dizziness	___Digestive Orders	___Neuritis	___ Rheumatism	___ Herpes
___ Diabetes	___Arthritis	___Venereal Disease	___ Hepatitis	___ Backaches

FAMILY HISTORY:

	Diabetes	Heart	Cancer	Back
Mother	___	___	___	___
Father	___	___	___	___
Brother, # of ___	___	___	___	___
Sister. # of ___	___	___	___	___
Brother, # of ___	___	___	___	___
Sister, # of ___	___	___	___	___

HAVE YOU HAD ANY OPERATIONS OR SURGERIES? ___Yes ___ No IF YES, LIST THE DATE

AND SURGERY (S) PERFORMED: ____

LIST THE DATE OF ANY PREVIOUS ACCIDENTS OR FALLS. ___Auto ___Recreational ___Work

Other:____

LIST ANY BROKEN BONES/FRACTURES/DISLOCATIONS: ______________________________

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS: ___Yes ___ No

HAVE YOU BEEN TREATED BY A DOCTOR FOR A HEALTH CONDITION IN THE PAST YEAR?

___YES ___ NO IF YES, DESCRIBE:____

LIST ANY MEDICATION YOU ARE TAKING:____

____

____

WOMEN ONLY:

I. ARE YOU PREGNANT OR DO YOU THINK YOU ARE PREGNANT? ___Yes ___ No

II. DATE OF LAST MENSTRUAL PERIOD: ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

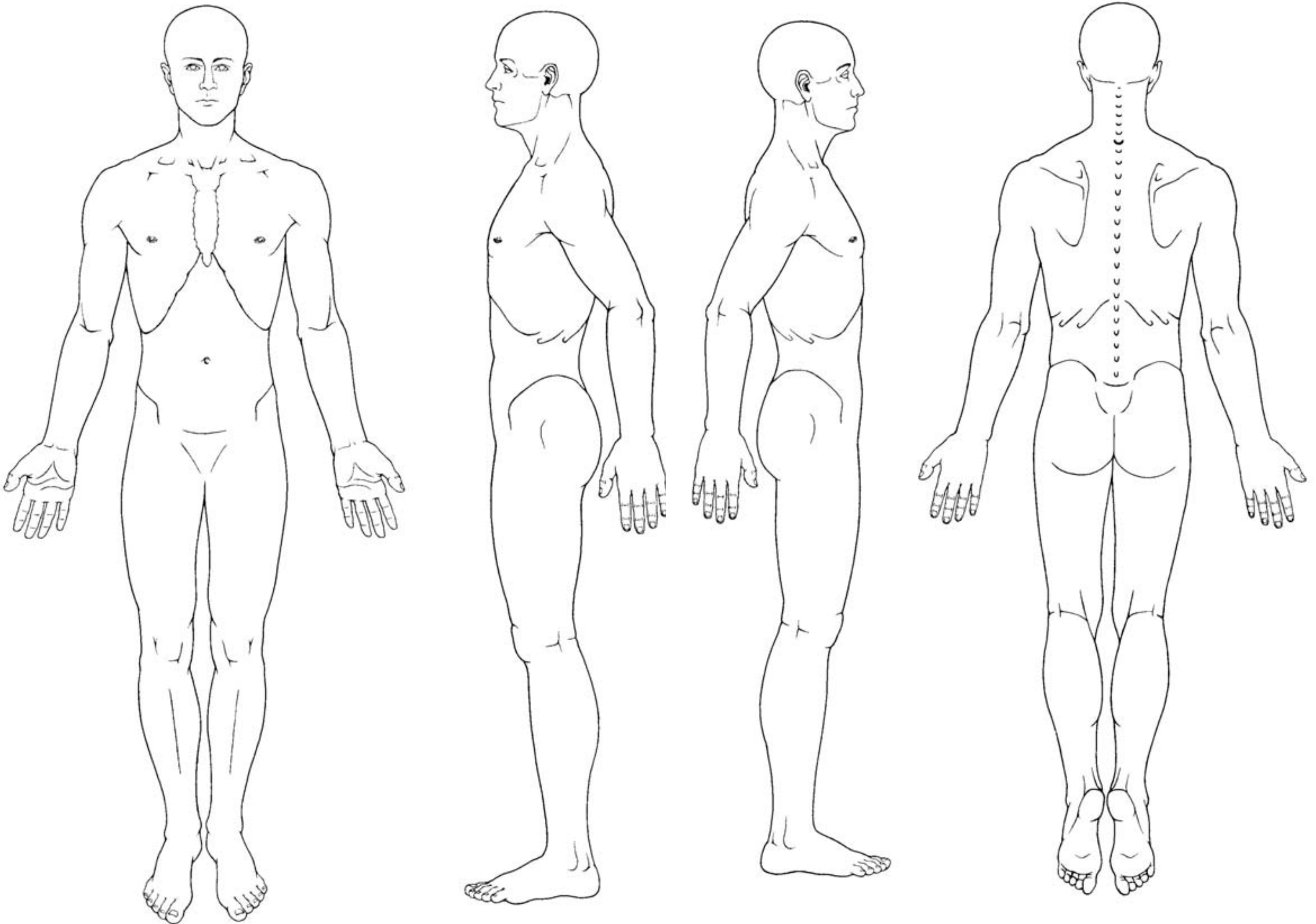
Patient's Signature: ____ Date:______________

Guardian's Signature Authorizing Care_____________________________ Date:______________

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT: ___________________________________DATE:____________________

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE ____DATE ____________________