

NEW PATIENT FORM

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____
Zip _____ Home phone _____
Birth date _____ Cell Phone _____
Age _____ Gender _____ Number of children _____
Employer _____
Work address _____
Work phone _____
Type of work _____
Marital Status _____
Social Security # _____
E-mail address _____
Payment method Cash Check Credit card

ABOUT THE SPOUSE / PARENT INFO

Name _____
Employer _____
Work phone _____
Type of work _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____
Have you seen or heard about us in/on: Paper Sign YP
Have you been adjusted by a Chiropractor before? Yes No
Reason for those visits? _____
Doctor's name: _____
Approximate date of last visit: _____
Has any adult in your family seen a Chiropractor? Yes No
Has any child in your family seen a Chiropractor? Yes No

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to:

- Job Sports Auto Fall
 Home Injury Chronic Discomfort Other

Please explain _____

If job related, have you made a report of your accident to your employer?

- Yes No

When did this condition begin? _____

Has this condition:

- gotten worse stayed constant comes and goes

Does this condition interfere with:

- Work Sleep Daily routine Other activities

Please explain _____

Has this condition occurred before? Yes No

Please explain _____

Have you seen other doctors for this condition? Yes No

Doctor's Name (s) _____

Type of treatment _____

Results _____

HEALTH HABITS

	No	Yes
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink coffee, tea or soda?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear:		
<input type="checkbox"/> Heel lifts <input type="checkbox"/> Sole lifts <input type="checkbox"/> Inner soles <input type="checkbox"/> Arch supports		

MEDICATIONS I NOW TAKE...

- | | |
|---|---|
| <input type="checkbox"/> Cholesterol medication | <input type="checkbox"/> Blood pressure medicine |
| <input type="checkbox"/> Stimulants | <input type="checkbox"/> Blood thinners |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Pain killers (including aspirin) |
| <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> _____ |

Vitamins & Supplements I now take: _____

Please **circle** the health concern or concerns you may be experiencing now or have experienced in the past. Each area of concern relates to an area of the spine and nerve function.

**Sore Throat - Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma - Allergies
High Blood Pressure
Heart Conditions**

C5
C6
C7
T1

C1
C2
C3
C4

**Headaches
Migraines - Dizziness
Sinus Problems
Allergies - Fatigue
Head Colds
Vision Problems
Difficulty Concentrating**

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

**Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis - Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers - Gastritis
Kidney Problems**

**Constipation - Colitis
Diarrhea - Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems**

L1
L2
L3
L4
L5
S
A
C
R
A
L

Other: _____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

For Women:

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking birth control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you experience painful periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have irregular cycles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have breast implants? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For All:

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Surgeries _____ | <input type="checkbox"/> Pain in arms/legs/hands | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Please print full name of responsible party (responsible parent if patient is under age 18)

Signature

Date

Guardian or Spouse's Signature Authorizing Care

Date

Who should receive bills for payment on your account?

Patient Spouse Parent Worker's Comp Auto Insurance Medicare Health Insurance

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Notice Of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Print): _____

Relationship to Patient: _____ (If under 18, responsible parent)

Signature: _____ Date: _____

Assignment of Benefits Form SSR

Practice Name _____

Address _____

City, State, Zip _____

Phone _____ Date _____

Patient _____

Employer _____

Claim Group _____

SS# / ID # _____

I hereby instruct and direct _____ Insurance Company
to pay by check made out and mailed to:

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to
make out the check to me and mail it as follows:

for the professional or medical expense benefits allowable, and otherwise payable to me under
my current insurance policy as payment toward the total charges for the professional services
rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS
POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and
I have agreed to pay, in a current manner, any balance of said professional service charges over
and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company,
adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my
behalf.

Dated at _____ this _____ day of _____

Signature of Policyholder

Witness