

Welcome

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name First Name M. I.

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

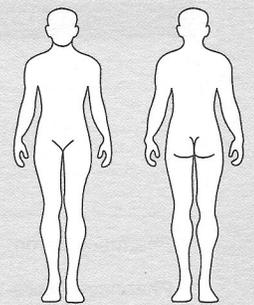
Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|--|---|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | | Other _____ |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

Arbitration Agreement
Physician/Patient Out-Patient Form

Arbitration is a way to decide health care complaints without going to court.

By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement only applies to the care that I receive in this office during the next year from the undersigned chiropractor, associate or any office assistants or substitutes employed by or assigned to my care by my chiropractor immediately following the execution of this form or during the time when this form is in effect. This agreement does not apply to disagreements over the fees charged.

State law gives me a choice of two ways to decide claims; either a trial by a judge or jury, or by arbitration. I have a right to a lawyer for a trial or arbitration.

If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a Doctor of Chiropractic. My doctor(s) and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association and my doctor's state or national association representative may appoint the panel members. State laws and the rules of the American Association will apply to all arbitration hearings, and may vary from state to state. All parties are delegated to investigate on their own and/or seek counsel.

I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives. This agreement also applies to any professional corporation or partnership that my doctor belongs to or works for. If I want to change my mind and cancel this agreement, I must notify my doctor in writing within 60 days after I sign. After 60 days, I cannot change my decision unless mutually agreed upon by all parties.

In most cases, a decision by arbitration panel is final and cannot be appealed.

This agreement to arbitrate is not a prerequisite to healthcare or treatment and may be revoked within 60 days after execution by notification in writing to:

Offered by

Patient Name (Printed)

Chiropractic Representative Signature

Patient Signature

Date

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

Parent/Guardian/Legal Representative Signature

Date

Patient Informed Consent

Congratulations on, choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentist, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These healthcare professionals are required to give you, the patient, advanced notice of any care risks, because healthcare is not an exact science. It is not reasonable to expect my doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death, or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result; but it does not necessarily indicate an error in clinical judgment. No guarantee of care or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in the clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then intercept the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy, C.M.T.) Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'s these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.) stroke, etc. The chance of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care based on the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I know agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of care has been made to me concerning results, care and treatment.

Patient Name (Printed)

Patient Signature

Date

Patient/Guardian Signature (if minor)

Staff/Witness 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 online or 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 cares. 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 HI. 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 cares. This would not affect the use of those records for the care given prior to 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 refused to sign this consent for the purpose 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

Patient Signature

Date