NEW PATIENT INFORMATION

Date:_________________

Patient Name

Last Name:______________________________ First Name: _________________________ Middle: _______________________

Gender: ☐ M ☐ F Date of Birth ____/____/______ Age_____ Social Security #__________________ Marital Status: M S W D

Permanent Address:____City:______________________State:_________ Zip:_________

Home Phone: _____________________ Cell Phone: ___________________ E-mail address:_____________________________________

Preferred Method of Contact: 🕊 Home 🕊 Cell Would you like automated email appointment reminders? ☐ Yes ☐ No

Occupation:_____________________________________ Employer:____

Spouse or Guardian

Last Name:______________________________ First Name: _________________________ Middle: _______________________

Emergency Contact

Last Name:______________________________ First Name: _________________________ Middle: _______________________

Address:____ Home Phone:___________________ Cell Phone:___________________

How were you referred to our office? ☐ Referred by someone___________________________________ ☐ Internet Search Engine

☐ Newspaper Ad ☐ Insurance provider website ☐ Driving by ☐ Event ☐ Phone-book ☐ Other_____________________________

I certify that the information I include on these forms is correct and I request services.

____ Date:_________________

Signature of patient or person acting on patient's behalf

Payment and Insurance Information

Payment Method (select all that apply): ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Health Savings Account (HSA) ☐ Other

My Financial Responsibility

I certify that the insurance information provided is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. I agree that if I am using insurance and my deductible has not been met, I will pay for my visit at the time of service.

____ Date:_________________

Signature of patient or person acting on patient's behalf

For those using insurance:

My Authorization

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

____ Date:_________________

Signature of patient or person acting on patient's behalf

History of Present Complaints

Chief Complaint(s):____

Purpose of this appointment:____

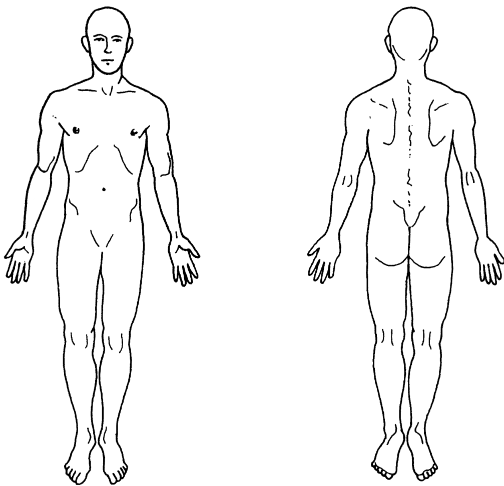
Date symptoms appeared or accident happened:_____________________________________

Is this due to: Auto___ Work____ Other____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:____________________

____

Days lost from work:_________________ Have you ever been to a chiropractor before? ☐ Yes ☐ No



TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Use the appropriate symbol(s) listed below.

- Ache: > > > > >
- Numbness: = = = = = =
- Pins & Needles: o o o o o
- Burning: x x x x x
- Stabbing: / / / / /
- Throbbing: ~ ~ ~ ~ ~

Circle Pain Level: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Past Medical History

Please list any past major injuries, illness, hospitalizations, or surgeries______________________________

____

Please list any ongoing medical problems:____

____

Please list any current medications, drugs, or supplements:_____________________________

____

Women: Are you pregnant? ☐ Yes ☐ No If yes, how many weeks?

Review of Systems

Have you had or do you now have any of the following symptoms/conditions?

Condition	Now	Past	Condition	Now	Past
Headaches	☐ Now	☐ Past	Loss of Balance	☐ Now	☐ Past
Neck Pain	☐ Now	☐ Past	Loss of Smell	☐ Now	☐ Past
Stiff Neck	☐ Now	☐ Past	Fainting	☐ Now	☐ Past
Sleeping Problems	☐ Now	☐ Past	Loss of Taste	☐ Now	☐ Past
Back Pain	☐ Now	☐ Past	Unusual Bowel Patterns	☐ Now	☐ Past
Nervousness	☐ Now	☐ Past	Feet Cold	☐ Now	☐ Past
Tension	☐ Now	☐ Past	Hands Cold	☐ Now	☐ Past
Irritability	☐ Now	☐ Past	Arthritis	☐ Now	☐ Past
Chest Pains/Tightness	☐ Now	☐ Past	Muscle Spasms	☐ Now	☐ Past
Dizziness	☐ Now	☐ Past	Frequent Colds	☐ Now	☐ Past
Shoulder/Neck/Arm Pain	☐ Now	☐ Past	Sinus Problems	☐ Now	☐ Past
Numbness in Fingers	☐ Now	☐ Past	Diabetes	☐ Now	☐ Past
Numbness in Toes	☐ Now	☐ Past	Indigestion Problems	☐ Now	☐ Past
High Blood Pressure	☐ Now	☐ Past	Joint Pain/Swelling	☐ Now	☐ Past
Difficulty Urinating	☐ Now	☐ Past	Menstrual Difficulties	☐ Now	☐ Past
Weakness in Extremities	☐ Now	☐ Past	Weight Loss/Gain	☐ Now	☐ Past
Breathing Problems	☐ Now	☐ Past	Depression	☐ Now	☐ Past
Fatigue	☐ Now	☐ Past	Loss of Memory	☐ Now	☐ Past
Lights Bother Eyes	☐ Now	☐ Past	Buzzing in Ears	☐ Now	☐ Past
Ears Ring	☐ Now	☐ Past	Circulation Problems	☐ Now	☐ Past
Broken Bones/Fractures	☐ Now	☐ Past	Seizures/Epilepsy	☐ Now	☐ Past
Rheumatoid Arthritis	☐ Now	☐ Past	Low Blood Pressure	☐ Now	☐ Past
Excessive Bleeding	☐ Now	☐ Past	Osteoporosis	☐ Now	☐ Past
Osteoarthritis	☐ Now	☐ Past	Heart Disease	☐ Now	☐ Past
Pacemaker	☐ Now	☐ Past	Cancer	☐ Now	☐ Past
Stroke	☐ Now	☐ Past	Coughing Blood	☐ Now	☐ Past
Ruptures	☐ Now	☐ Past	Alcoholism	☐ Now	☐ Past
Eating Disorder	☐ Now	☐ Past	HIV Positive	☐ Now	☐ Past
Drug Addiction	☐ Now	☐ Past	Scoliosis	☐ Now	☐ Past
Gall Bladder Problems	☐ Now	☐ Past	Other, please describe	☐ Now	☐ Past
Ulcers	☐ Now	☐ Past			

Family History

Please check off or list any major illness or diseases in your immediate family:

Mother	Father	Siblings	Children
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis
☐ Multiple Sclerosis	☐ Multiple Sclerosis	☐ Multiple Sclerosis	☐ Multiple Sclerosis
☐ Lung Disease	☐ Lung Disease	☐ Lung Disease	☐ Lung Disease
☐ Bone Disease	☐ Bone Disease	☐ Bone Disease	☐ Bone Disease
☐ Other____________	☐ Other____________	☐ Other____________	☐ Other____________
☐ Other____________	☐ Other____________	☐ Other____________	☐ Other____________

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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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. If you pay for a service out-of- pocket in full, you can ask us not to share that information for the purpose of payment or operations with your health insurer. We will say “yes” unless a law requires us to share that information.
6. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fund-raising communications at any time.
7. 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.
8. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
9. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
10. This notice is effective on the date stated below.
11. 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.

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.

The following person(s) have my permission to receive my personal health information:

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

____ Date:_________________

Signature of patient or person acting on patient’s behalf

For further information regarding this notice, please contact Dr. Ned Crowley at 507-453-9229