Date _______________ Patient # ____________

PATIENT INFORMATION

How were you referred to our office? ____

Name ______________________________ Date of Birth ____________________ Age ______________

Address ______________________________ City ____________________ State ______ Zip ______________

E-Mail ____________________________ Home Phone # ____________________Cell Phone # ____________________

Do we have your permission to send you emails (appointment reminders, office announcements, etc.)? Yes/No

Social Security Number ____________________________ Your Occupation ______________________________

Employer____ Days lost from work ______________

Marital Status: M S W D Spouse ________________________Spouse's Date of Birth____________ How many children? _____

Race *(circle 1 only)* American Indian Alaska Native Asian Black or African American Native Hawaiian Other Pacific Islander Alaska Native White

Ethnicity *(circle 1 only*) Non-Hispanic or Latino Hispanic or Latino
Preferred Language ____________________________

IN CASE OF EMERGENCY

Name of nearest relative or friend ______________________ Address ____________________ Phone ______________

INSURANCE INFORMATION

IS THIS A RESULT OF AN AUTO ACCIDENT? Yes / No IS THIS A RESULT OF A WORKERS COMPENSATION INJURY? Yes / No

Please circle any and all insurance coverage that may be applicable in this case: Major Medical, Worker's Compensation, Medicaid, Medicare, Auto Accident, Other.

Name of Primary Insurance ____

Name of Secondary Insurance Company (if any) ____

AUTHORATIZATION 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.
Patient's Signature ____ Date ______________

Guardian's Signature Authorizing Care ______________________________________ Date ______________

Active Care Chiropractic Patient History/Personal History

Patient Name ____ Date ________________

Purpose of this appointment ____

Please circle below to indicate your level of pain:

☺ No Symptoms 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Extreme Symptoms ☹

Have you been treated for any health condition by a physician in the last year? Yes / No If yes, describe__________

____

Surgeries/Hospitalizations ____

____

Fractures____

Please List any medications you are currently taking ___________________________

____

Are allergic to any drugs or medications (please list)? ________________________

Family Medical Doctor _______________________Date of last Physical examination ______________

Smoking Status? (Circle one) Current every day smoker, Current some day smoker, Former Smoker, Never Smoker

Drink alcohol? Yes / No Use recreational drugs? Yes / No

Family Medical History

Put an **M** for Mother, **F** for Father, and **B** for Both

( )Rheumatoid Arthritis ( )Diabetes ( )Cancer ( )Heart Disease

( )Multiple Sclerosis ( ) Stroke (indicate age when it happened) Mother___ Father___

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you?
Please circle yes or no.

Headaches Frequency _________	Yes/No	Loss of Balance	Yes/No
Neck Pain	Yes/No	Fainting	Yes/No
Stiff Neck	Yes/No	Unusual Bowel Patterns	Yes/No
Sleeping Problems	Yes/No	Diabetes	Yes/No
Back Pain	Yes/No	Indigestion Problems	Yes/No
Chest Pains/Tightness	Yes/No	Joint Pain/Swelling	Yes/No
Dizziness	Yes/No	Weakness in Extremities	Yes/No
Shoulders/Neck/Arm Pain	Yes/No	Arthritis	Yes/No
Numbness in Fingers	Yes/No	Muscle Spasms	Yes/No
Numbness in Toes	Yes/No	Weight Loss/Gain	Yes/No
High Blood Pressure	Yes/No	Depression	Yes/No
Difficulty Urinating	Yes/No	Fatigue	Yes/No
Breathing Problems	Yes/No		

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes / No Uncertain

Doctor's Signature ______________________________________ Date___________________

Heath Schipp, DC

Active Care Chiropractic 3240 Lone Oak Rd Paducah KY 42003 270-554-7661

Patient #______________________

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used 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 not obligated to agree to those restrictions.
3. A patient 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 affect 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. 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 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.
8. We may use your information to provide appointment reminders or recall notices (such as postcards or letters) or information about products and services that may be of interest to you. If you do not wish to receive these notices by mail you may opt out by checking the following:

❐I do not wish to receive mailings or appointment reminder calls

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

____

Patient Name/Signature Date