PATIENT INFORMATION

How were you referred to our office?			Patient #
FULL NAME	DATE OF BIRTH	HOME PHONE #	CELL PHONE #
STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	EMAIL	MARITAL STATUS ❍ Single ❍ Married ❍ Divorced ❍ Widowed
EMPLOYER	EMPLOYER ADDRESS AND PHONE	OCCUPATION
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S EMPLOYER
EMERGENCY CONTACT	EMERGENCY CONTACT ADDRESS	EMERGENCY CONTACT PHONE #

INSURANCE INFORMATION

IS THIS A RESULT OF AN AUTO ACCIDENT ❍ YES ❍ NO	IS THIS A RESULT OF A WORKER'S COMPENSATION INJURY? ❍ YES ❍ NO
NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE

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 I am responsible for all cost of chiropractic care, regardless of coverage.

Patient Signature: Date:

If patient is a minor please have guardian sign.
Guardian's Signature Authorizing Care: Date:

HEALTH HISTORY

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, PLEASE DESCRIBE:

PLEASE LIST ALL SURGERIES OR HOSPITALIZATIONS	FRACTURES

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

PLEASE LIST ANY ALLERGIES TO MEDICATIONS

YOUR FAMILY MEDICAL DOCTOR	DATE OF LAST PHYSICAL EXAMINATION

PLEASE CHECK ONE ❍Current every day smoker ❍Current some day smoker ❍Never Smoker ❍ Former Smoker	DRINK ALCOHOL ❍YES ❍NO	USE RECREATIONAL DRUGS? ❍YES ❍NO

HAVE YOU HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING SYMPTOMS WHICH ARE OR HAVE BEEN OF SIGNIFICANT DISTRESS TO YOU?

❍Yes ❍No Headaches	❍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
❍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	WOMEN ONLY: Is there any possibility you could be pregnant?❍Yes ❍No

FAMILY MEDICAL HISTORY

Rheumatoid Arthritis ❍Mother ❍ Father	Diabetes ❍Mother ❍ Father	Cancer ❍Mother ❍ Father
Heart Disease ❍Mother ❍ Father	Multiple Sclerosis ❍Mother ❍ Father	Stroke ❍Mother ❍ Father

DOCTOR'S SIGNATURE Dr. Heath Schipp	DATE

PATIENT NAME _____ ID#_____

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 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