Hamm CHIROPRACTIC & WELLNESS

Confidential Patient Health Record

Today's Date:___/___/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Newspaper
☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Last:_____ **First:**_____ **Middle:** _____**Suffix:**_____

Birth Date: ____/____/_____ **Age:**_____ **Sex: Male / Female**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____

Spouses Name: _____

What is your email address that you prefer to have communication sent to you from this office?_____

Emergency Contact

Last:_____ **First:**_____ **Middle:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** _____

Work Phone: (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Phone: (_____) _____-_____ **Fax #:** (_____) _____-_____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

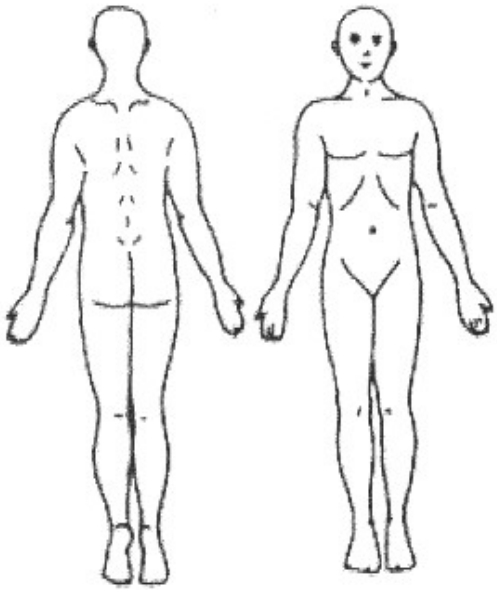
Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



Previous Care for this Same Condition:

☐ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ **Yes** ☐ **No. If yes, Who? (Name)** _____
Type of Treatment: _____ **Were you satisfied with the results of your treatment?** ☐ **Yes** ☐ **No**

Explain: _____

Dr.'s Note:

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____
Were you satisfied with your care? ☐ Yes ☐ No. Why? _____

Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other_____
For how long? _____ Were they prescribed by a doctor? ☐ Yes or ☐ No.

Do you currently smoke tobacco of any kind? __Yes __Never been a smoker __Former smoker
If yes, How often do you smoke: __Current Everyday smoker __Current Someday smoker
Packs per day _____ Years Smoked _____

List current medications including dosage, if known. If no medications are currently taken then check here:___
1)_____ 2) _____
3)_____ 4) _____
5)_____ 6) _____
7)_____ 8) _____

List any known allergies that you have to any medications. If no allergies are known then check here: ___
1)_____ 2) _____
3)_____ 4) _____

Has any doctor diagnosed you with Hypertension presently? ___ Yes ___No If yes, what kind?
Has any doctor diagnosed you with Diabetes presently? ___ Yes ___No If yes, what kind? Type I or II?
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes__ No __ Not Sure___
Has any doctor diagnosed you with any type of significant health syndrome presently? Yes__ No__ Not Sure___
If yes, what kind? _____

Primary Care Physician: _____

Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ alzheimers	☐ depression	☐ influenzal pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental sugery	☐ joint replacement	☐ spinal fusion
☐ cardic catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) □ Myself ONLY

□ Spouse □ Worker's Comp □ Auto Insurance □ Medicare □ Medicaid □ Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

I hereby authorize the providers of Hamm Chiropracitc to administer such procedures as may be deemed necessary in the diagnosis and treatment of the patient. I hereby authorize release of any medical information regarding this visit to my insurance and or primary care physician, and also ASSIGN to the Provider all payments from Medicare, Blue Cross/Blue Shield, Medicaid, and my insurance if not listed. I Understand that I am financially responsible for all charges whether or not paid by my insurance.

I Understand that Dr. Hamm at Hamm Chiropractic may not be a participating provider with my insurance. I Understand that I am responsible for the charges not covered by my insurance. A late fee of $17.50 will be added to all accounts unpaid for 90 days. I will also be liable for all legal and collection fees. I understand and Agree to the above conditions.

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Patient's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

Payment for services is due on the day of service. As part of our service, we will submit your claim to your insurance.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

DATE OF BIRTH _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. **This information is kept private except uses involved in your healthcare.**

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

_____

I authorize Hamm Chiropractic & Wellness to speak with the following people regarding my healthcare:

_____

With my consent, Hamm Chiropractic & Wellness, may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operation, such as appointment reminders, insurance items and information pertaining to my clinical care. With my consent Hamm Chiropractic & Wellness may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

PATIENT:

X_____ _____

Signature of patient/ Legal Representative Date