WELCOME TO GRUNDY CENTER CHIROPRACTIC, P.C.

Confidential Patient Information

Today's **Date** _____

Name _____ **SSN** _____ **Age** _____ **Birth Date**_____

Address _____ **City** _____ **State** _____ **Zip** _____ **Gender** _____

Cell Phone _____**Home Phone** _____ Work Phone _____

We offer FREE Email and Text Reminders: *Email* _____ *Cell Phone Company* _____

Occupation _____Employer_____ Marital Status: M S Other Spouse Name_____

Emergency Contact _____ **Phone** _____Address_____

Purpose of this appointment/Symptoms _____

This injury will be filed as personal injury to: ☐ Auto Insurance ☐ Worker's Compensation ☐ N/A

Date symptoms appeared or accident happened _____Have you ever had the same or a similar condition?

Yes ___ No ___ If yes, when and describe_____

Have you ever seen a Chiropractor? _____ **When was your last chiropractic adjustment?** _____

Tobacco Use: Never ____ or Amt per day _____ Rate your pain level from 1 to 10, with 10 being the highest: _____

Please check all that apply. Do you now or have you ever suffered from:

GENERAL:

___ Allergies_____
___ Dizziness/Fainting
___ Headaches
___ Numbness/Tingling
___ Diabetes

CARDIOVASCULAR:

___ High/Low Blood Pressure
___ Swelling/Edema
___Chest Pain
___ Rapid/Slow Pulse

CANCER: _____

Mental Illness:

_____

PREGNANT? ___Yes ___No

MUSCLE & JOINT:

___ Arthritis
___ Bursitis
___ Foot Trouble
___ Low Back Pain
___ Neck Pain/Stiffness
___ Pain between Shoulders
___ Sciatica
___ Shoulder Pain
___ Elbow/Wrist/Hand Pain
___ Hip Pain
___ Leg Pain
___ Knee Pain
___ Jaw Pain/TMJ

GASTRO-INTESTINAL:

___ Constipation
___ Diarrhea
___ Gall Bladder Trouble
___Hernias
___ Hemorrhoids
___ Heartburn/Indigestion

EYE/EAR NOSE/THROAT:

___ Nosebleeds
___ Colds/Sinus Infection
___ Earache/Ringing

GENITO-URINARY:

___ Bed Wetting
___ Infertility
___ Urgency/Frequent/
___ Painful Urination

RESPIRATORY:

___ Asthma
___ Chronic Cough
___ Shortness of Breath

Female Menstral Symptoms:

_____

For the following, please mark F (family history) and/or P (personal history):

_____ Cancer _____ Anemia
_____ Heart Disease _____ High Blood Pressure
_____ High Cholesterol _____ Diabetes

What surgeries or serious illnesses have you had? (Include dates)_____

Have you ever had a broken bone, major accident or fall? _____

What medication, drugs or supplements are you taking? _____

How did YOU find our office or whom may we thank for your referral? _____

Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give is a referral of friends and family.

AUTHORIZATION & RELEASE:

I have answered the above questions to the best of my knowledge and understand that providing inaccurate information is dangerous to my health.

I also authorize payment of insurance benefits directly to Grundy Center Chiropractic, P.C. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of all services, which are rendered to me that my insurance company does not pay. I also understand that if I suspend or terminate my care and my treatment, any fees for professional services, which are rendered to me, will be immediately due and payable. Should my account become delinquent, I will be responsible for any interest (to accrue at the rate of 18% annually, commencing 30 days after the initial bill for services is issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. I hereby authorize Grundy Center Chiropractic to release any information to my insurance company/attorney acquired in the course of my examination or care. I understand that a scanned photocopy of my insurance card and authorization will be deemed as valid as the original.

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, the undersigned, have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I accept chiropractic care, the authorization and release statements on this basis.

Patient/Guardian Signature _____ Date _____

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an X-ray evaluation. I have been advised that X-ray can be hazardous to an unborn child and that 10 days following the onset of a menstrual period are generally considered to be safe for X-ray Exam.

Patient/Guardian Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Gabriel L. Smith at 605 G Avenue, Grundy Center, IA 50638 (319) 825-4400

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE I, the patient signed below, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Patient/Guardian Signature _____ Date _____