WHIPPLE sports + wellness

New Patient Health History

Thank you for your interest in chiropractic care at Dr. Todd Whipple's office. Please complete this health history. All the information obtained in this history will help us assess you today and assist you in attaining your optimal health and wellness.

Patient Information

Patient's Name ______________________ Today's Date ______________

Date of Birth ______________ Age __________ ❏ Male ❏ Female

Address ______________ City __________ State __________ ZIP __________

Cell Phone __________ Alternate Phone __________ Email __________

Cell Phone Provider ______________________

Occupation ______________ Employer ______________

Marital Status ❏ Married ❏ Single ❏ Separated ❏ Widowed Number of children __________

Referred by ______________________

Emergency Contact

Emergency Contact Name ______________ Contact Phone ______________

Insurance Provider Information

Name of primary policy holder ______________ Relationship to Patient ______________

Date of birth of primary policy holder ______________________

Name of Health Insurance ______________________

Is this a group or individual plan? ❏ Group ❏ Individual

Policy ID# ______________ Group No. ______________

Is this visit related to an auto accident? ❏ Yes ❏ No

Medical History

BP __________ Cholesterol ______________

Date of last physical exam __________ With whom ______________

Major injuries/surgeries/illnesses/radiology findings ______________________

Medications/Drugs you are taking ______________________

Vitamins/Supplements/Herbs ______________________

Purpose of Visit

What is the reason for your visit today? ______________________

Are you in training for a particular sport? ❏ Yes ❏ No Sport ______________

Describe your current exercise program ______________________

Release and Privacy Practices

WHIPPLE sports + wellness

Updated Privacy Practices as of 3/11/2018

ASSIGNMENT and RELEASE

I have read and understand my chiropractic/physical therapy benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Whipple Sports & Wellness and the release of medical records or other information necessary for the processing of my claims.

I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services that I will be directly responsible for all charges. The amount collected at time of service does not always reflect the coinsurance or copay quoted by the insurance companies. I also understand that any appointment without a prior 24 hour notice is subject to a cancellation fee. I authorize the use of the signature below on all insurance submissions.

HIPAA AND PRIVACY PRACTICES

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how health information may be used and disclosed and how you can get access to this information. Please let us know if there are any questions.

We may share your health information to treat you, collect payment, run our office, inform you of other services, discuss your case with family, do research, include you in care classes, thank you for referring other patients, health and safety reasons, reporting to workers comp., reporting to law officials, reporting victims of abuse, court hearings and fillings. You have the right to request a copy of health records, request confidential communications, request a list of whom has been informed of your condition, amend your protected health information, ask us to limit the information we share, advise our management if you believe your privacy rights have been violated.

I understand and agree to the following:

1. The privacy practices have been satisfactorily explained to me and I have received a copy or had an opportunity to receive a copy of the Notice of Privacy Practices.
2. The doctor(s) may use my confidential health information in the manner previously described.

Patient Signature ______________________________ Date ______________________

Please provide your cell phone and carrier to opt in for our text message reminder system.

Patient Cell Phone ______________________________ Carrier ______________________

For more information, questions or concerns, please contact us at Whipple Sports + Wellness, **512-350-8633**.