SANTEE CHIROPRACTIC CLINIC
DR. PATRICK LEONARD

CLINIC INFORMATION:

A : 627 Bass Dr Santee, SC 29142 P : (803) 813 - 4357

E : santeechiropractic@gmail.com

WELCOME TO SANTEE CHIROPRACTIC CLINIC

Thank you for entrusting us with your care!

TODAY'S DATE (MM/DD/YY)

☐☐ / ☐☐ / ☐☐

PATIENT INFORMATION

Full Name:

Social Security:

Occupation:

Date of Birth: ☐☐ / ☐☐ / ☐☐

Employer:

Age:

Cell Phone:

Gender: ☐ Male ☐ Female

Home Phone:

Marital Status:

Other Phone:

Email:

Emergency Contact:

Emergency Contact Phone:

Were you referred by anyone? If so, who may we thank?

ADDRESS

Street Address :

City :

State :

Zip Code :

Country:

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s):

Relationship to Patient:

Patient Signature

Office Signature

PATIENT CONDITION

Briefly describe your symptoms:

How did your symptoms appear?

When did your symptoms appear?

Nature of Condition:
- ◯ Initial Onset (within last 3 months)
- ◯ Recurrent (multiple episodes of <3 months)
- ◯ Chronic (continuous duration > 3 months)

Is this condition getting progressively worse? ◯ Yes ◯ No ◯ Unknown

Is it constant or does it come and go?

Average Pain Intensity:

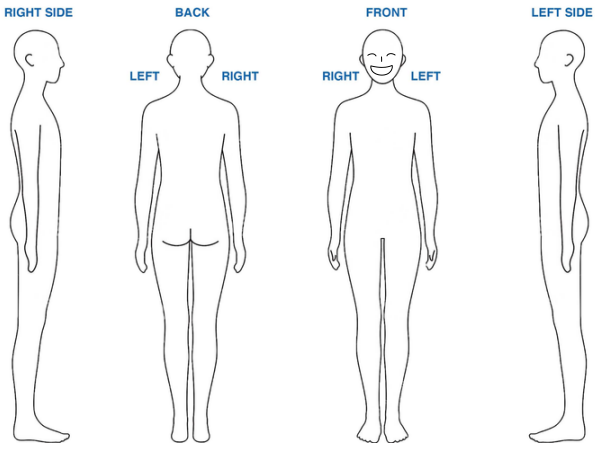
Past 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Activities or movements that are painful to perform: ◯ Sitting ◯ Standing ◯ Walking ◯ Laying Down ◯ Bending

Does it interfere with your: ◯ Recreation ◯ Work ◯ Daily Routine ◯ Sleep

MARK AN X ON THE PICTURE WHERE YOU ARE EXPERIENCING PAIN, NUMBNESS, OR TINGLING.



Type of Pain: ◯ Sharp ◯ Dull ◯ Throbbing ◯ Numbness ◯ Burning ◯ Tingling ◯ Cramps ◯ Stiffness ◯ Aching ◯ Shooting ◯ Swelling ◯ Other

Exercise:
- ◯ None
- ◯ Moderate
- ◯ Daily
- ◯ Heavy

Work Activity:
- ◯ Sitting
- ◯ Standing
- ◯ Light Labor
- ◯ Heavy Labor

Habits:
- ◯ Smoking — Packs/Day
- ◯ Alcohol — Drinks/Week
- ◯ Coffee/Caffeine Drinks — Cups/Day
- ◯ High Stress Level — Reason

HEALTH HISTORY

What treatment have you already received for your condition? ◯ Medications ◯ Surgery ◯ Chiropractic Services ◯ Physical Therapy ◯ None ◯ Other

Name and address of other doctor(s) who have treated you for your condition:

Date of Last: Physical Exam | Spinal X-Ray | Blood Test

Spinal Exam | Chest X-Ray | Urine Test

Dental Exam | MRI, CT-Scan, Bone Scan

Are you Pregnant? ◯ Yes ◯ No Due Date:

Please mark any of the following conditions that you have been diagnosed with <u>in the past</u>:

◯ AIDS/HIV	◯ Breast Lump	◯ Heart Disease	◯ Osteoporosis	◯ Scarlet Fever
◯ Alcoholism	◯ Bronchitis	◯ Hernia	◯ Pacemaker	◯ Stroke
◯ Allergy Shots	◯ Bulimia	◯ Herniated Disc	◯ Parkinson's Disease	◯ Suicide Attempt
◯ Anemia	◯ Cancer	◯ High Cholesterol	◯ Pinched Nerve	◯ Thyroid Problems
◯ Anorexia	◯ Chemical Dependency	◯ Kidney Disease	◯ Pneumonia	◯ Tuberculosis
◯ Appendicitis	◯ Diabetes	◯ Liver Disease	◯ Polio Problem	◯ Tumors / Growths
◯ Arthritis	◯ Epilepsy	◯ Migraine	◯ Prothesis	◯ Ulcers
◯ Asthma	◯ Fractures	◯ Headaches	◯ Rheumatic Arthritis	◯ Other
◯ Bleeding Disorder	◯ Gout	◯ Multiple Sclerosis	◯ Rheumatic Fever	

Describe any injuries or surgeries you have had:

		Date:
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Vitamins/Herbs/Minerals	Allergies

ASSIGNMENT AND RELEASE

1. I authorize the release of information to my family physician and employer.
2. I authorize the release of information to insurance companies.
3. I authorize the performance of photographs and x-rays to be used for treatment purposes.
4. I authorize the performance of other diagnostic and therapeutic procedures and treatments.
5. I authorize my insurance benefits to be paid directly to:

SANTEE CHIROPRACTIC CLINIC
627 BASS DRIVE
SANTEE, SC 29142

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.
I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNATURE: _____ **DATE:** _____

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If contact is made by phone but no one is reached, a message will be left on your voicemail. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization to review.

PATIENT SIGNATURE: _____

PATIENT NAME PRINTED: _____

DATE: _____

AUTHORIZED PROVIDER REPRESENTATIVE:

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMITS OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

PATIENT SIGNATURE: _____

PATIENT NAME PRINTED: _____

DATE: _____

AUTHORIZED PROVIDER REPRESENTATIVE: