NEW PATIENT INTRODUCTION

(please print clearly)

Today's Date___________

Name____Age______Date of Birth____/____/____

Address__________________________________City____________State__________Zip________

Home #______________Work #_______________Cell #_____________ ❑ Single ❑ Married

Occupation____________________________Employer__________________________________

Referred by____________________________Previous Chiropractic Care (yes) (no)

Where_________________________________When_____________________________________

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED

UNLESS OTHERWISE ARRANGED

AUTOMOBILE ACCIDENT HISTORY

Dr. Rick Huskey
3820 E. 51st, Suite A
Tulsa, OK 74135

DATE ______________

NAME: ____ SS#: ______________
LAST FIRST MI

ADDRESS: ____ HOME PHONE: ______________

CITY: ______________________ STATE: ______ ZIP: ________ CELL PHONE: ______________

BIRTHDATE : ____________ ( )MALE ( )FEMALE ( )SINGLE ( )MARRIED ( )DIVORCED ( )WIDOWED

EMPLOYER: ____ PHONE: ______________

SPOUSE'S NAME: ______________ DOB: ______________ SPOUSE'S SS#: ______________

SPOUSE'S EMPLOYER: ______________________ EMPLOYER PHONE: ______________

EMERGENCY CONTACT: ______________________ PHONE: ______________

Due to HIPPA regulations we will not discuss financial or medical records with anyone but our patient. If you would like to give our office authorization to discuss financial and/or medical records with your spouse or any other party please list their name and relation: ______________

NAME OF PRIMARY CARE PHYSICIAN: ______________ PHONE: ______________

INSURANCE INFORMATION

THEIRS

Insurance Company ____

Insured Party ____

Insurance Company Contact ______________________ Phone ______________

Policy No. ______________________ Claim No. ______________

Vehicle Driver ____

YOURS

Insurance Company ____

Insured Party ____

Insurance Company Contact ______________________ Phone ______________

Policy No. ______________________ Claim No. ______________

Vehicle Driver ____

Name of Health Insurance ______________________ Group & ID# ______________

Time and date of accident ____________ ❑ AM ❑ PM ____/____/____

Please explain in detail how your accident occurred? ____

____

You were heading? ❑ North ❑ South ❑ East ❑ West on ______________ (street or highway)

Other vehicle was heading? ❑ North ❑ South ❑ East ❑ West on ______________ (street or highway)

Number of people with you in the car? ________

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Did you lose consciousness? ❑ Yes ❑ No If so, for how long? ______________

You were struck from ? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Backseat, Using ❑ Seat belt ❑ Shoulder belt ❑ Other protective devices

Did you feel pain immediately after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When ________

What were your immediate symptoms following the accident? ____

Where were you taken after the accident? ❑ Home ❑ Emergency Room ❑ Other, ______________

What treatment was rendered? ____

Was any doctor(s) consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name ______________________ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Doctor's diagnosis? ______________________ Did you see the doctor(s) more than once? ________

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, were they due to ❑ A previous car accident, or ❑ On the job injury?

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

Have you retained an attorney? ❑ No ❑ Yes, Name ______________________ Phone ______________

Vehicle Make & Model you were in ______________________ Estimated Damage $ ______________

Vehicle Description that hit you ____

HEALTH QUESTIONNAIAIRE

PLEASE CHECK (✓) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

MUSCULO-SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Disc problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Muscle spasms
- ☐ Broken bones
- ☐ Shoulder pain
- ☐ Carpal Tunnel

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

GASTRO-INTESTINAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

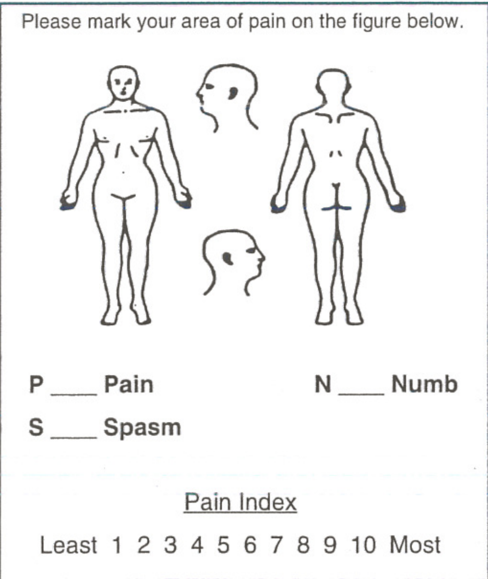
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia / Loss of sleep

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Exercise
- ☐ Drug Abuse
- ☐ ______________________

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**



CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

	Y	N
Do you have diabetes?	☐	☐
Is problem worse while lying down?	☐	☐
Have you recently had fever, sweats, chills?	☐	☐
Does this problem wake you from a sound sleep?	☐	☐

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office 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 this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: ______________________________

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: ______________________________

Parent's or Guardian's Signature: ______________________________

Name ______________________________ Date ______________

Ethnicity _______ Hispanic/Latino _______ Non-Hispanic/Non-Latino

Race: _____ American Indian _____ Alaskan Native _____ Asian _____ African American/Black

_____ Native Hawaiian _____ Caucasian/White

Smoking Status: _____ Yes _____ No Frequency ____________ Quit?/When ___/___/___

No known Drug Allergies or List Allergies : ______________________________

____

____

No Medications or List of Medications : ______________________________

____

____

____

Family History and indicate the relationship:	Father	Mother	Sister	Brother
Anxiety _____	_____	_____	_____	_____
High Blood Pressure _____	_____	_____	_____	_____
Cancer/What Kind ______________	_____	_____	_____	_____
Depression _____	_____	_____	_____	_____
COPD _____	_____	_____	_____	_____
Heart Disease/Attack _____	_____	_____	_____	_____
Diabetes _____	_____	_____	_____	_____
Headaches/Migraines _____	_____	_____	_____	_____
Arthritis _____	_____	_____	_____	_____
Scoliosis _____	_____	_____	_____	_____

Huskey Chiropractic

Dr. Rick Huskey * Dr. Chandler Huskey

3820 E. 51st St., Suite A
Tulsa, OK 74135

Notice of Receipt of Privacy Notice of Huskey Chiropractic

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Huskey Chiropractic Clinic, in force as of April 14, 2003 and that all of my questions have been answered to my satisfaction in language that I can understand.

______________________________ Print Name of Individual	______________________________ Signature of Individual
______________________________ Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	______________________________ Relationship
Date Signed: ____________________	Witness: ____________________

Patient's Name:____

As a courtesy, our office will file your Medical Pay/PIP claims. Your signature, assignment of benefits, authorizes the payment to come to our office. Once our office receives the payment that requires my endorsement, please accept my signature as said endorsement for services rendered by Dr. Rick Huskey. In the event that the case is not settled, I agree to be responsible for all charges.

____

Signature Date

AUTHORIZATION & ASSIGNMENT FORM

In consideration of Dr. Rick Huskey undertaking to care for me, I agree to the following:

1. Dr. Rick Huskey is authorized to release any information they deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment in full to Dr. Rick Huskey of any sum I now or hereafter owe Dr. Rick Huskey, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to Dr. Rick Huskey for the charges made for the services refuses to make such payment upon demand by Dr. Rick Huskey, I hereby assign and transfer to Dr. Rick Huskey the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize Dr. Rick Huskey to prosecute said action in my name as you see fit. I understand that whatever amounts Dr. Rick Huskey does not collect from the insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to Dr. Rick Huskey. I also agree that Dr. Rick Huskey may elect, in its sole discretion, to seek payment in full from any and all applicable insurance sources and shall not be obligated to accept adjusted payment amounts from my health insurer as payment in full if other insurance coverage also applies or provides coverage for the charges incurred.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Oklahoma.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effect until revoked by both parties in writing.

______________________________ ______________

Patient or Legal Guardian Signature Date

3820 E. 51st Street, Suite A Tulsa, OK 74135 Phone:918-747-0939 Fax:918-747-3939