Date: Patient Status: New Update

Patient Information

Patient Name:
Date of Birth: | Age: | Sex:
Address:
City: | State: | Zip:
Primary Phone: ( ) - | Alternate: ( ) -
Marital Status: Single Married Other
Employment Status: Full-Time Part-Time Retired Student Unemployed
Employer:
Primary Care Provider:

Payment/Insurance Information

Do you have insurance with Chiropractic coverage?: Yes No Unsure
Subscriber/Policy Holder Name:
Date of Birth: | Age: | Sex:
Relationship to Patient: Self Parent Spouse Other
Name of Insurance Provider:
Secondary Insurance Provider:
Person Responsible for Account: Patient Subscriber Other
Billing Address (If Different from Above):

Injury Information

What is the primary reason for your visit today?:
What was the initial cause of injury, if known?:
When was the approximate date of injury/symptoms began?:
What was your pain level at the time of injury on a scale of 1-10, with 1 being No Pain and 10 being Worst Possible Pain?: 0 - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Since then, has your pain level: Increased Decreased Stayed the Same
Did the injury occur at your workplace? Yes No
Did the injury occur as the result of an automobile accident? Yes No

Please Complete Back Side →

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Health History Information

Height: | Weight:
Are you currently pregnant? Yes No
Do you have a pacemaker or other implanted cardiac device? Yes No
Do you take **ANY** prescription or non-prescription medications? Yes No
Please list all prescriptions and medications here, **OR** provide a separate list if you have one: Please list all surgical procedures here, **OR** provide a separate list if you have one:

Please check all conditions you have **currently or previously** experienced:

Past	Present	(Please **X**)	Past	Present	(Please **X**)	Past	Present	(Please **X**)
	/	Neck Pain		/	Heart Attack		/	Asthma
	/	Upper Back Pain		/	Chest Pains		/	Chronic Sinusitis
	/	Mid-Back Pain		/	Stroke		/	Diabetes
	/	Low Back Pain		/	Angina		/	Excessive Thirst
	/	Shoulder Pain		/	Kidney Stones		/	Inc. Urination
	/	Elbow/Arm Pain		/	Kidney Disorders		/	Allergies
	/	Wrist/Hand Pain		/	UTI		/	Depression
	/	Hip/Thigh Pain		/	Painful Urination		/	Lupus
	/	Knee/Leg Pain		/	Bladder Control		/	Epilepsy
	/	Ankle/Foot Pain		/	Prostate		/	Dermatitis/Eczema
	/	Jaw Pain		/	Weight Change		/	HIV/AIDS
	/	Swollen/Stiff Joints		/	Loss of Appetite		/	COVID-19
	/	Arthritis		/	Abdominal Pain		/	Alcohol abuse
	/	General Fatigue		/	Ulcer		/	Tobacco Use
	/	Muscle Weakness		/	Hepatitis		/	Substance abuse
	/	Dizziness/Faintness		/	Liver/Gall Bladder			
	/	Visual Disturbance		/	Cancer/Tumor			
	/	Medication Rxs		/	Pregnancy			
	/	Headaches		/	Hi Blood Pressure			

Has any member of your **immediate family** been diagnosed with:

☐ Rheumatoid Arthritis	☐ Heart Problems	☐ Diabetes
☐ Cancer	☐ Lupus	☐ Another Severe Health Condition

I affirm that all of the above information is complete and accurate. I understand the Office Privacy Policy concerning my medical records (required by HIPAA as of 4/14/2003), and I understand that I have the right to request a copy of the Privacy Statement at any time.

Signature: _____ Date: _____

Treatment Expectations and Side Effects:

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Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, cold application, and manual muscle therapy) are considered safe and effective methods of care. While Wilcox Chiropractic works to provide the most positive outcome for each patient, as with any medical treatment, there is no guarantee or warranty for a specific cure or result.

Side effects are almost always temporary and normal, including soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. Serious complications are estimated to be in the range of ½ to 2 incidents per million adjustments of the neck, and 1 per million adjustments of the low back. These complications may include injury to the arteries of the neck, injuries to the spinal discs, and spinal fractures. Our goal is to ensure our patients are well informed, and we encourage you to request additional information on the risks and benefits of spinal adjustments from Dr. Wilcox during your examination.

I have read and understand this statement.

Signature: _____ Date: _____

If patient is a minor: You hereby authorize Dr. Donald R. Wilcox and whomever he may designate as his assistant to administer treatment as he deems necessary to your child (the patient indicated on these forms).

Parent/Guardian Signature: _____ Date: _____

Patient Disclosure

In order to develop a treatment plan that is most beneficial to you as an individual, it is of the highest importance that all requested health information is provided in a complete and accurate manner. Failure to disclose any information regarding your injury, medical history, medications, or lifestyle may put you at risk.

This office does not accept worker's compensation cases or no-fault cases. We only accept payment via the patient or their private insurance company. We urge you to always report a workplace injury appropriately via worker's compensation and seek treatment with medical professionals who can assist you with your claim. A workplace injury that seems minor now may eventually contribute to a chronic problem or even permanent disability. We are always happy to provide a referral to a chiropractor in your area who accepts worker's compensation and/or no-fault cases.

I have read and understand this statement.

Signature: _____ Date: _____

Billing Agreement

As a patient at Wilcox Chiropractic, you authorize payment directly to Dr. Donald R. Wilcox of all insurance benefits otherwise payable to you for services rendered. You authorize Wilcox Chiropractic to release any information required to secure payment of benefits by your insurance company, and permit the use of your signature from this form for all insurance submissions.

You are financially responsible for all charges, and your insurance may or may not provide coverage for Chiropractic care. Furthermore, some insurers will not cover maintenance visits once treatment for a specific injury is complete. Payment is due at the time of service for all treatments.

I have read and understand this statement.

Signature: _____ Date: _____

Employee Initials:

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

How do we typically use or share your health information?: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775. We will not retaliate against you for filing a complaint.

Employee Initials: