Patient Information

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Driver's License: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

Payment Method: _____ Card/Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Date

HIPAA Disclosure Form

Hospital: _____ Doctor: _____

Patient Name: _____ Date: _____

Listed Address: _____

Preferred Correspondence Address: _____

Listed Phone No. _____ Preferred Phone No. _____

Listed Email Address: _____

Preferred Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? ❑ Yes ❑ No

May we identify ourselves over the phone? ❑ Yes ❑ No May we leave messages? ❑ Yes ❑ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Authorization to Bill Insurance

Client: _____ Guardian (if Minor): _____

Phone: _____ Email: _____

Address: _____

Insurance Company: _____ Policy No. _____

Doctor: _____ Clinic: _____

Phone: _____ Location: _____

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

_____ _____

Signature Date

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your physician are listed below:

_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

The total cost for the services/items recommended by your physician are:

$_____

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*

Health Risk Assessment Form

General

Name: _____
DOB: _____ Gender: _____
Height: _____ Weight: _____
Race: _____

Medical History

Date of last check-up: _____
Allergies: _____
Medications: _____
Previous Medications: _____
Injuries: _____
Surgeries: _____
Blood Pressure: _____
Cholesterol: _____

History of...

Cancer: ❑ Me ❑ Relation: _____
Diabetes: ❑ Me ❑ Relation: _____
Stroke: ❑ Me ❑ Relation: _____
Heart Disease: ❑ Me ❑ Relation: _____
Heart Attack: ❑ Me ❑ Relation: _____
Depression: ❑ Me ❑ Relation: _____
Bipolar Disorder: ❑ Me ❑ Relation: _____

Females

Last date of most recent cycle: _____
Date of last PAP Smear: _____
Date of last breast exam: _____
Date of last rectal exam: _____
Year of last pregnancy: _____
Did the pregnancy come to term? ❑ Yes ❑ No

Males

Date of last prostate exam: _____

Well-Being

Rate your overall well-being: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

Rate your health: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

How safe do you feel? ❑ Very ❑ Not Very ❑ Not at all

How satisfied are you with your life? ❑ Very ❑ Not Very ❑ Not at all

How often do you feel depressed? ❑ Always ❑ Often ❑ Occasionally ❑ Never

Current therapist: _____
Frequency of sessions: _____
Starting date: _____

Nutrition

How many daily servings of vegetables do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of fruit do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of grains do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of meat do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of sugar/carbs do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

Drug Use

How often do you smoke tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
How often do you chew tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
When did the tobacco use start? _____
How many cigarettes do you have per day? _____

How many alcoholic drinks do you have per week? _____
How often do you binge drink (5+ drinks in 1 hour)? ❑ Occasionally ❑ Weekly ❑ Daily ❑ Never
Have you ever been treated for alcoholism? _____
How often do you black out/lose time? _____

Have you ever used recreational drugs? _____
Which drugs? _____
Have you ever abused prescription drugs? _____
Which drugs? _____
Have you ever been treated for drug use? _____
How often do you use recreational drugs? ❑ Daily ❑ Weekly ❑ Often ❑ Occasionally ❑ Rarely ❑ Never

Exercise

How many days per week do you work on cardio? _____
Length of time spent on cardio each session: _____
How many days per week do you work on strength? _____
Length of time spent on strength each session: _____
Injuries/conditions that interfere with exercise: _____
_____

Other

Volunteer Activities: _____
Who do you live with? _____
Do you require...? ❑ Hearing Aid ❑ Walker ❑ Cane ❑ Oxygen Tank ❑ Glasses
How often do you get headaches? _____
Food Sensitivities: _____
How many hours of sleep do you get per night? _____
How restful is your sleep? ❑ Restful ❑ I wake up once or twice ❑ I wake up often ❑ Fitful

ADULT HEALTH HISTORY

Date _____

Name _____

Date of birth _____ Age _____

General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

Signature _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.