# Patient History and Information Sheet

Gainesville Chiropractic Center / Kevin B. Wheeler DC

## About You

Today's Date_______/_______/_______

Name : _______________________________ MI :_______

What do you prefer to be called? _______________________________

☐ Male ☐ Female D.O.B. ____/____/____ Age _______

SS# _____-_____-_____

Address:_______________________________

City_______________________ State______ Zip_________

Home Phone : _______________________________

Work Phone : _______________________________

Cell Phone : _______________________________

Employer : _______________________ How Long ?________

Employer's Address _______________________________

City_______________________ State______ Zip_________

Occupation _______________________________

Marital Status: Single______ Married ______ Divorced______ Widowed________

Spouses Name: _______________________________

Referred By: _______________________________

## Insurance Information

Company Name : ____________

Co-Pay :______ Deductible:______

Is the deductible met? Y / N

Address:_______________________

_______________________

Phone # _______________________

Insured's Name#_______________________

Insured's SS_______________________

Insured's DOB ____/____/____

Insurance ID # _______________________

Group # _______________________

Relation to insured:____________

Insured's Employer: ____________

_______________________

Please inform front desk if there is a secondary insurance company.

## What is the Reason of this Visit

Have you ever seen a Chiropractor before? ☐ Yes ☐ No

If yes, Please explain : _______________________________

The reason for this visit is a result of ( Circle) work, sports, auto, trauma or chronic

Explain what happened: _______________________________

_______________________________

Please describe the pain and its location: _______________________________

_______________________________

When did the condition begin? _______________________________

Is this condition getting worse? ☐Yes ☐ No ☐ Constant ☐ Comes and Goes

Has this condition interfered with your ( Circle ) work, sleep, or daily routine

_______________________________

Have you been treated by a medical doctor for this condition? ☐ Yes ☐ No

If yes, where? _______________________________

## Emergency Contact Information

Who should we contact? _______________________________

Relation: _______________________________

Home Phone #_______________________________

Work Phone #_______________________________

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# Patient History and Information Sheet Cont.



## Health History

Are you taking any of the following medications?

☐ Nerve Pills ☐ Pain Killers ( Including Aspirin ) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s)______________

Have you ever had any of the following diseases or medical conditions?

| | | |
|---|---|---|
| Y N Heart Attack /Stroke | Y N Heart Surg. / Pace Maker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV / AIDS | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema / Glaucoma | Y N Anemia |
| Y N High / Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers / Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones / Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or ever had: ____________________

____________________

Please list anything that you may be allergic to: ____________________

____________________

List any past serious accidents with dates: ____________________

____________________

Do you smoke? ☐ No ☐ Yes / How Much ________ How Long?______

Are you wearing ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress?_______ Is it comfortable ☐ Yes ☐ No

**For Women:** Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ No ☐ Yes / How Long?____

Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services.
- Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

**Signature X**____________________ **Date** ____/____/____

## Account Information

**Person ultimately responsible for account**

Name: ____________________

Relation: ____________________

Billing Address: ____________________

____________________
city state zip

SS# ____________________

DL # ____________________

Work Phone #____________________

**Payment Method:**

☐ Cash ☐ Check ☐ Credit Card

☐ I hereby authorize assignment of my insurance rights and benefits directly to Gainesville Chiropractic Center / Kevin B. Wheeler DC for services rendered.

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# Acknowledgement for Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of your Protected Health Information**
Your Protected Health Information will be used by Gainesville Chiropractic Center / Kevin B. Wheeler D.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use of Disclosure of Your Information**
You may request a restriction on the use of disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use of\r disclosure that has already occurred prior to the date on which you revocation of consent is received will not be affected.

**Reservation of Right to Change privacy practice**
This office reserves the right to modify the privacy practices outlined in the Notice.

**Signature**
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

________________________________________
**Name of Patient (Print)**

________________________________________
**Signature of Patient** **Date**

________________________________________
**Signature of Patient Representative** **Date**

________________________________________
**Relationship of Patient Representative to Patient**

________________________________________
**Office Representative** **Date**

**Name of Person / Persons we may release your PHI to:**

________________________________________
________________________________________
________________________________________
________________________________________