Revised: 4-4-2012

New Patient Questionnaire

Date ___________________

Is your visit due to an accident? (Y)__ (N)___ (If yes, please complete accident questionnaire) Cell Phone (_______)_____________________

First_________________________MI____Last____ Home Phone (________)____________________

Address____ City______________________________State______Zip____________________

Age__________ Birth Date_______/_______/________ Single / Married / Other Number of Children________ SS# ________-______-________

Occupation_________________________________ Employer_______________________________ Work Phone (________)____________________

Gender: M___ F___ Student Full Time / Part Time / NA Email address:____

Name of Wife / Husband / Legal Guardian_______________________________________Occupation____

Employer____ SS# __________-_________-__________ Birth Date________/________/________

Name of Emergency Contact (Not living with you)__________________________________ Relation_________ Phone (______)_________________

Medical Doctor(s) consulted within the past year:

Name:____ Condition:____

Name:____ Condition:____

INSURANCE INFORMATION

ID # _________________ Name of Policy Holder ____ Policy Holder's DOB____/____/_____

Policy Holder's SS#_________ - _________ - _________ Relationship To Patient : Self / Spouse / Child / Other _______________

Insurance Carrier's Name ____

Policy Holder's Employer____ Employer's Address____________________________

Employer's Phone #(________)_________________ Insurance ID# _________________ Group or Claim # ________________________

Does your employer require his or her own claim form? Yes____ / No____
Is your visit due to work injury? Yes__ / No__ If yes, was injury reported to employer within 24 hours of injury? Yes__ / No__
Is your visit due to an auto accident?Yes__ / No__ If yes, do you have auto insurance and have you claimed accident? Yes__ / No__
Is your visit due to another type of accident? Yes__ / No__ If yes,described____

____

I understand and agree that I am responsible for all financial obligations for all services, supplies and equipment for the above noted patient account. I further understand and agree that if, for any reason, this account should become delinquent I will be responsible for and pay for any and all costs of collection including reasonable attorney fees.

Patient Signature ____ Date_______________

Guardian's Signature ____ Date_______________

Witness Signature ____ Date_______________

INFORMED CONSENT TO MEDICAL/CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physiological therapies and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors of medicine/chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of medicine/chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I will discuss with the doctor (s) and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other prescribed medical procedures, and I understand that results are not guaranteed.

I understand that in the practice of medicine/chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and strains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is on my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

____ ______________

Patient/Guardian Signature Date

____ ______________

Witness Signature Date

Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain healthcare providers to obtain their patients’ consent for uses and disclosure of health information about patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:____ Signature:____________________________________ Date:______________

Medical History

Patient Name: ____________________________________ **Date of Birth**: ___________________________________

Medical History (please circle the following conditions you may have had or have now)

Alcoholism	Diabetes	Irregular Periods	Neuritis
Allergy	Diarrhea	Low Blood Sugar	Pleurisy
Anemia	Depression	Malaria	Pneumonia
Arthritis	Eczema	Measles	Polio
Back Aches	Epilepsy	Menstrual Cramps	Sinus
Back Pain	Gall Bladder	Migraine	Stroke
Blood Vessel Disease	Gout	Miscarriage	Thyroid Problems
Cancer	Headaches	Multiple Sclerosis	Tuberculosis
Cold Sores	Heart Attack	Mumps	Ulcer
Constipation	Heart Disease	Neck Pain	Venereal Disease
Convulsions	High Blood Pressure	Nervousness	Whooping Cough

Reason for appointment & related health problems	**Time Period**	**Have you had this before?**	**Injury Related?**
1.____	___________	**Yes / No**	**Yes / No**
2.____	___________	**Yes / No**	**Yes / No**

Briefly describe your current symptoms:
____

____

Previous Surgeries (please list all types):

1. Type____ **Date** ____________________

1. Type____ **Date** ____________________

1. Type____ **Date** ____________________

Are you allergic to any medications? ( ) Yes ( ) No - Please List____

____

Are you currently taking any medication? ( ) Yes ( ) No - Please List____

____

Are you pregnant? ( ) Yes ( ) No - Date of last menstrual period : ___________________________

Patient Signature:____ **Date:**____________________

Guardian's Signature: _____________________________________ **Date:** ____________________