Patient Information

Legal First Name: ______________________________ MI: ________ Last Name: _______________________________________

Street: ____ ___________Apt: ______________

City: ____ State: ___________ Zip: _____________________________

Social Security #:________________________________ Marital Status: S M W D Spouse: ___________________________

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other_______________

Race: White _____American Indian/Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander_____ Black or African American _____ Hispanic or Latino _____ Decline to answer _____Other____________________

Ethnicity: Hispanic or Latino _____Not Hispanic or Latino _____ Decline to answer _______

DOB: ____________________ Home Phone: ________________________________ Work Phone: _________________________

Cell Phone: _____________________________________ Cell Carrier____

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email hm: ____ Email wk: ____

Emergency Contact: __________________________________ Phone Number: ____

Whom may we thank for referring you to our office? ____

Occupation: ____ Employer: ____

Employer Address: ____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N if no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: ____ M.I. __________ Last Name: _______________________________

Policy Holder's Date of Birth: _______________________ Policy Holder's SS#: ____

Policy Holder's Employer: ____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: ____ M.I. ___________ Last Name: ________________________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____

Policy Holder's Employer: ____

Current Health Problem

Patient History

Are you seeing anyone else for other problems or health conditions? ▫ Yes ▫ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

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____
____
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Past health history
Have you… Yes No If yes, include date & provider seen

...been diagnosed with Diabetes? ▫ ▫ ____

Type I____or Type II_____

…been treated for hypertension? ▫ ▫ ____

Do you smoke? ▫Never ▫Former Smoker ▫Current/Every Day Smoker ▫Current Some Day Smoker

<u>Medications</u>
What medications are you currently taking? Include vitamins, herbs, minerals…
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by
Please be as specific as possible

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Do you have allergies? ▫Food ▫Environmental ▫Medication
List Type of Allergy and Reaction

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

•Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
•Obtaining payment from third party payers (e.g. my insurance company);
•The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to restrictions on how my protected heal information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ___________ day of _________________ 20_______.

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Signature (Parent/Guardian's if under 18) Relationship to Patient

Assignment & Release

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 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 doctor's 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 or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature:

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Consent of Professional Services and Release of Information

I herby 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 furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office 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 service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:

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