Confidential Patient Information

Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ Age: _____ Social Security #: _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Occupation: _____ Employer/Company Name: _____

Employer's Address: _____ Employer's Phone: _____

Spouse's Name: _____ Spouse's Employer/Company Name: _____ Spouse's Occupation: _____

Spouse's Employer's Address: _____ Spouse's Employer's Phone: _____

Patient's nearest relative (for emergency purposes): _____ Phone: _____

Is this condition due to a work related injury or auto accident? ☐ Yes ☐ No
If yes, ask the receptionist for an accident form.

Health History: Check symptoms you currently have or have had in the past year:

GENERAL
- ☐ Allergy
- ☐ Depression
- ☐ Headaches
- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Sweats

EYES
- ☐ Blurred vision
- ☐ Eye pain

EARS/NOSE/THROAT
- ☐ Earache
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Nose bleeds

MUSCLE/JOINT/BONE
- ☐ Arm pain
- ☐ Hip pain
- ☐ Back pain
- ☐ Leg pain
- ☐ Feet pain
- ☐ Neck pain
- ☐ Hand pain
- ☐ Shoulder pain
- ☐ Sciatica
- ☐ Poor posture

GASTRONINTESTINAL
- ☐ Appetite poor
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Congestion

WOMEN ONLY
- ☐ Extreme menstrual pain
- ☐ Breast lumps
- ☐ Painful intercourse
- ☐ Cramps/backache
- ☐ Hot flashes
- ☐ Other _____

INTEGUMENTARY
- ☐ Bruise easy
- ☐ Itching
- ☐ Sores/Ulcers

NEUROLOGICAL
- ☐ Dizziness
- ☐ Tingling _____
- ☐ Numbness _____
- ☐ Vertigo
- ☐ Weak grip
- ☐ Difficulty of speech
- ☐ Paralysis
- ☐ Loss of memory
- ☐ Un-coordination

ENDOCRINE
- ☐ Weight gain
- ☐ Weight loss
- ☐ Heat intolerance
- ☐ Cold intolerance

MEN ONLY
- ☐ Breast lumps
- ☐ Erection difficulty
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

CONDITIONS
- ☐ AIDS
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Appendicitis
- ☐ Bursitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headache
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Anemia
- ☐ Bed wetting
- ☐ Colon trouble
- ☐ Enlarged thyroid
- ☐ Frequent urination

Health History…continued

Date of last physical : _____

Are you pregnant? □ Yes □ No If yes, due date: _____

List any fractured bones you've had: _____

Do you take vitamins or minerals? □ Yes □ No

Are you wearing Heel lifts? □ Yes □ No Sole lifts? □ Yes □ No
Inner Soles? □ Yes □ No Arch supports? □ Yes □ No

Do you drink alcohol? □ Yes □ No
If yes, how much? _____

Do you exercise? □ Yes □ No
If yes, how much? _____

Do you drink coffee? □ Yes □ No
If yes, how much? _____

List any medical concerns, serious illnesses or operations you have had: _____

List any medications you are currently taking: _____

Have you tried Chiropractic care before? _____ If yes, name of Doctor: _____

How did you hear about us? (referred by): _____

Reason for today's visit: _____ Height _____ Weight _____

Are you interested in learning about our weight loss program? □ Yes □ No

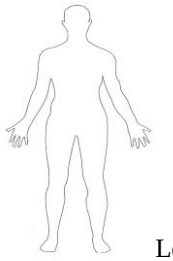
***Have you had X-rays/MRI/or a CT Scan taken within the last year that relates to the condition you are being seen for today? _____

If yes, what office or hospital were they taken at? _____

Please mark area(s) of injury or discomfort on the model below using the following symbols:
Numbness (NNN) Pins & Needles (PPP) Burning (BBB) Aching (AAA) Stabbing (SSS)
Circle any area(s) of pain not represented by a symbol

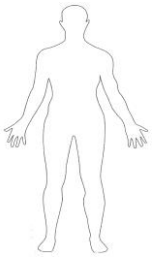
Also Indicate Level of Pain (1 – 10)

None Unbearable
1 2 3 4 5 6 7 8 9 10



Right Left

Front



Left Right

Back

Would you like us to send a report to your family doctor? □ Yes □ No

If yes, family doctor's name and address: _____

_____

Insurance Information

PAYMENT IS EXPECTED AT TIME OF SERVICE!

Dr. Kelly and his staff **ARE NOT** responsible for knowing your medical coverage. If you have questions about your insurance coverage, it is your responsibility to contact your insurance carrier. To avoid billing problems, notify the office immediately if there are any changes with your address, phone number or insurance coverage.

Health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 for professional services rendered me will be immediately due and payable.

My initials indicate I have read and understand the above information regarding my medical coverage. _____ (initials)

I will be paying today by: ☐ Cash ☐ Check ☐ VISA/MasterCard ☐ Other: _____

Missed Appointment Policy

A No-show charge of $25.00 will be assessed on the third missed appointment (not cancelled-no show).
It will be assumed that the patient has lost interest in his/her health and will be referred elsewhere.
My initials indicate I have read and understand the missed appointment policy. _____ (Initials)

Laser Therapy Treatment and Spinal Decompression Therapy

I understand and agree that all Laser treatments and Spinal Decompression Therapy rendered me are charged directly to me. I also understand that these treatments are NOT covered by my medical insurance and that payment is due at the time of service. _____ (initials)

HIIPA: Consent for purposes of Treatment, Payment, & Healthcare Operations

My "protected health information" means health information, including my demographic information collected from me and created or received by my physicians. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Tri-City Chiropractic for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Tri-City Chiropractic. I understand that the doctors at Tri-City Chiropractic may refuse to diagnosis or treat me if I do not consent to the use of disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Tri-City Chiropractic is not required to agree to the restrictions that I may request. However, if Tri-City Chiropractic agrees to a restriction that I request, the restriction is binding on Tri-City Chiropractic.

I understand I have the right to review Tri-City Chiropractic's Notice of Privacy Practices prior to signing this document. Tri-City Chiropractic's Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Tri-City Chiropractic. The Notice of Privacy Practices for Tri-City Chiropractic is also provided on request at the main administration desk of this practice. The Notice of Privacy Practices also describes my rights and Tri-City Chiropractic's duties with the respect to my protected health information.

Tri-City Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that a Tri-City Chiropractic doctor has taken action in reliance on this consent.

_____ _____ _____

Signature of Patient or Personal Representative Relationship (if not patient) Date