Introduction Patient Case History

Date:_____

Name (Mr. Mrs. Miss Ms.): _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Mobile Carrier:_____ Receive Text? Yes/No

Email:_____ Married/Single/Divorced/Widowed

Number of Children:_____ Are You Pregnant?_____

Date of Birth: _____/_____/_____ Social Security No: _____-_____-_____

Occupation:_____Employer:_____Work Phone:_____

Emergency Contact:_____ Phone Number:_____

Previous Chiropractic Care? Yes/No When:_____ Doctor's Name:_____

Other Physicians Seen:_____ Condition:_____

Please let us know if a recent MRI has been taken.

Name of Insurance Company:_____

Primary Insurance Holder:_____Primary Holders Date of Birth:_____

Any Recent Surgeries:_____ Date:_____ Description:_____

Any Recent Accidents:_____ Date:_____ Description:_____

Medications:_____ Allergies to RX:_____

Smoking habits: Never smoked_____Former smoker_____Current smoker_____packs/day_____

Alcohol consumption: None_____ Socially_____ Habitually_____

Who (or what source) can we thank for your referral?_____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that bothers you the most today?

_____

When did your pain begin? _____

Pain Level: best 0 1 2 3 4 5 6 7 8 9 10 worst

Is your condition: getting better getting worse no change

Is your condition: constant frequent occasional

Type of pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Radiating: Left/Right Base of Skull Shoulder Arm Hand Hip Leg
Knee Foot Ribs Other:_____

What makes it better? Ice Heat Rest Movement Stretching
Other:_____

When does it feel better? No Change Morning Mid-day Evening Night

What makes it worse? Sitting Standing Walking Lying down Sleep
Overuse Other:_____

When does it feel worse? No Change Morning Mid-day Evening Night

Does your problem affect your daily activities? No Mild Moderate Severe

Describe: _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? (Auto, Fall, Work, ect.) _____

Date of accident: _____

History

CHECK YOUR PRESENT AND PAST SYMPTOMS					
Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

	FAMILY HISTORY							
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	☐	☐	☐	_____
Grandmother	☐	☐	☐	☐	☐	☐	☐	_____
Grandfather	☐	☐	☐	☐	☐	☐	☐	

Are you currently working? Yes No

If yes, do you: ___Sit more than 50% of the day
___Light Manual Labor __Heavy Manual Labor

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

Assignment of Health Benefits

The parties appearing below, on the ____ day of _____, _____, hereby agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in Mr./Mrs./Ms. _____ policy issued by _____.

I, the above mentioned name, hereafter referred to as "Patient", understand and voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy with the above mentioned company in consideration for treatment rendered by Dr. Jeff Hijazi D.C., hereafter referred to as "Doctor".

That patient, the policy holder, requests, orders and directs the above mentioned company to pay Doctor directly to his/her office at 151 E 33rd St Ste 100 Edmond, OK 73013, the sum due Doctor for treatment rendered as a result of illness/injuries.

That Patient gives Doctor the exclusive right to secure the funds assigned the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered.

That Doctor and Patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below: That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms, and conditions appearing herein.

Insurance Information

I understand & agree that health and accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports & forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand & 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 & treatment, any fees for professional services rendered to me will be immediately due & payable. All co-pays, co-insurance amounts, and deductible are due at the time of service unless otherwise arranged. We accept cash, check, Visa, Mastercard, American Express, and Discover.

I have read, understand, and agree to this Assignment of Benefits and Insurance Information.

Patient Signature_____ **Date** _____

Doctor_____

Office Procedures

Appointment Reminders: Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this consent is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave a message on you answering machine or with the individual at your home or place of employment.

Authorization for Payment: Your doctor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to your insurance company, lawyers, third party insurance company or the credit bureau. This disclosure will be made if we need their assistance to receive reimbursement for your services, or we need their assistance because the party responsible for reimbursing your service has improperly processed your claim. By signing this form you are giving us authorization to send them this information. You are also giving them authorization to re-disclose your information to the party responsible for the payment of your services, the association's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Referrals: If you refer a friend, family member or, colleague into our office, we would like to send you a thank you card, and put your name on our referral board thanking you for sending them to us. If someone referred you to our office, we would like to send a card with your name it to them as a token of our gratitude. By signing this form you are giving us authorization to send these cards in the mail.

Financial Arrangements: We have an open front desk and all of our financial arrangements are discussed at the front counter. If you feel you need a more private place to discuss your financial arrangement we can move to the back office. Please notify the office staff or doctor if arrangements need to be made.

Privacy Policy: I have read and been provided with (if requested) the practice Privacy Policy. The Privacy Notice will be available to you in the future per your request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this form, and encouraged me to read the Privacy Policies followed by this office. By signing this form you are agreeing with the above statement.

Printed Name: _____ Date:_____

Signature: _____