Inice Gough, DC PC, 270 S. Spruce St, PO Box 2178, Sisters, OR 97759. (541) 549-3583

Patient Confidential Information

Due to recent changes in the healthcare industry, we are asked to obtain all the following information on patients treated in our office.

Date:_________________

Name:______________________________________ Date of Birth ___/____/_____

Name you prefer to be called by:________________________

How did you choose our clinic? ___Referral (Who?_________________________)

___The Nugget ___Website ___Google Search ___Walk/Drive by

Mailing address:____

City:_______________ State:___________________ Zip:_______________

___Email:____

___Home Phone: (_____)________-_____________May we leave a message:___yes; ___no

___Work Phone: (_____)________-______________ May we leave a message:___yes; ___no

___Cell Phone: (_____)_________-______________ May we leave a message:___yes; ___no

Check your above contact numbers with a 1 for primary contact, 2 for secondary, etc including e-mail

Social Security: ______-______-_______

Emergency Contact Name:_________________________Relation: __________________________
Phone:_____________________________

Employer:______________ Address:__________________________ Phone:___________________

Primary Language:____English ______Spanish _____ Other:______________

RACE: _____White ___Hispanic or Latino ___American Indian or Alaskan Native ___Asian

____African American or Black ___Decline to Answer

ETHNICITY: ____Hispanic or Latino ___Not Hispanic or Latino ____Decline to Answer

Page 2:
PAST HEALTH HISTORY **Patient Name: ______________________Date: ___/___/_____**

Have you been...
Diagnosed with High Blood Pressure? ___No ___Yes; Provider:____________________

Diagnosed with Diabetes?__No__Yes; Type1___ Type2___ Provider: ___________________

Please fill out the following if you know them:

Height:_________ Weight:_________ Blood Pressure: _____/______

Do you smoke? ___Never ___Former Smoker ___Current every day ___ Current and only some days

How much alcohol do you consume in a week? _____x/week ___Beer ___Liquor ___wine

How much coffee or caffeinated drinks do you consume on a daily basis? _____/day; or____/week

MEDICATIONS

Please list vitamins, herbs, minerals, or other supplements you are currently taking:____
____

For medications below: Please list: **strength, and dosage per day.**

Or, ____None (You do not take medications)

Medication	**Prescribed by: Please list prescribing physician**
• _________________________	____
• _________________________	____
• _________________________	____
• _________________________	____
• _________________________	____

If more, list here:____

Do you have any allergies to medication? _____Yes ______No

If yes, please list the medication and the reaction:____________________________________
____

Patient Name: ________________________________ **Date:** ___/___/_____

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REASON FOR YOUR VISIT TODAY:____

How long have you been experiencing the above symptoms?_____________________________________

Where specifically is the problem located?____

Please list the activities that aggravate your symptoms (such as sitting, sitting to standing, bending, etc)

____

Type of pain: __Sharp __Dull __Throbbing __Burning __Achy __Shooting __Stiff __Tingling

Other:_________________________________

Rate the severity of your pain (1=mild pain to 10=severe pain) 1 2 3 4 5 6 7 8 9 10

Preferably, give a range of your pain (such as 3-6, or 6-10)______________________________

Is your pain: ___Constant ___Frequent ___Intermittent ____Occasional

How often do you feel the pain? (Is it daily or a few days a week, and is it felt more in the morning, afternoon, evening, etc):____

What treatment have you already received for your symptoms listed above in **REASON FOR YOUR VISIT**? ___Medication ___Surgery ___Physical therapy ___Other:______________; _____None

Name and address of those who have treated you for the symtoms you are here for today(If any):

____

List the surgeries you have had. Please list the dates of the surgery or year and the result or outcome:

______________________________ Date:___________________________ Result:__________________

______________________________ Date:___________________________ Result:__________________

______________________________ Date:___________________________ Result:__________________

If more than three, list all below:

____

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ASSIGNMENT AND RELEASE

Insurance Information and Financial Policy

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/Guardian's Signature:______________________________________Date:_____________

Printed Name:___________________________________

If you ARE NOT the primary policy holder of your health insurance, please list the name and birthdate of the PRIMARY holder.

Name:___________________________________ Date of Birth: ___/___/______

Consent of Professional Services and release of information

I hereby authorize and release the doctor and whom ever she may desigante as her assistants, to adminster treatment, physical examination, laboratory procedures, x-ray studies, chiropractic care or any clinic services that she deems necessary in my case; I furthermore authorize 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 emplyer 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, attorney's offices, welfare funds, or the patient's employer.

Patient's/Guardian's Signature:____**Date:**_____________

Printed Name:____________________________

PRIVACY NOTICE RECEIPT VERIFICATION

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Inice Gough, DC PC, dba: Three Sisters Chiropractic with my authorization and consent to use and disclose my or my under age dependants protected health care information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

Patient's Name (Print)__________________________________ **Date:** __________________

Patient or Guardian's Signature: _____________________________________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people. Office appointments which are cancelled with less than 24 hours notification may be subject to a $50.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period will be charged a $50 no show fee for each visit missed.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (541-549-3583).

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) ____

Signature of Patient or Patient Representative ___________________________

Today's Date _____________