WELCOME TO A BETTER LIFE CHIROPRACTIC AND MEDICAL MASSAGE

9882 Colerain Avenue
Cincinnati, Ohio 45251
www.abetterlifechiro.com
(513)385-2273

PATIENT INFORMATION

(PLEASE PRINT)

Name_____SS#____-__-_____Date: _____/____/_____

Phone: Home_____ Work_____ Cell _____

Address_____City_____State_____Zip_____

Date of Birth:__/__/__E-Mail_____Marital Status__s__m__w__d

Employer_____

Seeking help for: _____Auto Accident _____Work Injury _____Other conditions

Have you had Chiropractic Care in the last year? _____yes _____no

If the primary policy holder is someone other than you, please give the following information:

Name:_____ SS#_____DOB_____
(please give health insurance information to receptionist)

ACKNOWLEDGEMENT

I, _____,consent to exams, tests, x-rays, and treatment if **John S. Smith, D. C.** deems them medically necessary in the course of my visit today. I realize that there is no guarantee of results from the above exams, tests, x-rays, or treatment. All x-rays are the property of A Better Life Chiropractic by state law, and I understand that if I want copies I will be charged a fee for materials and labor. I certify that all the above information is true and correct. I understand that I am financially responsible for my services at A Better Life Chiropractic and that I may be billed for any deductible amounts not covered by my insurance company, whether applied to in-network or out-of-network benefits, and for any unpaid co-payment amounts from previous visits. I understand that if I am told by any personnel at A Better Life Chiropractic that I have coverage, this may indicate in-network or out-of-network coverage, and it is up to me to know my insurance plan benefits.

Patient Name_____Signature_____

Guardian Name_____Signature_____

EXPERIENCE HEALTH!

We look forward to helping you!

A Better Life Chiropractic

John S. Smith, D.C.

9882 Colerain Avenue

Cincinnati, OH 45251

Review of Systems

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

General Symptoms

___Allergy (type)_____
___Bronchitis
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Loss of sleep
___Loss of weight
___Nervousness
___Neuralgia
___Night Sweats
___Numbness or pain
In arms/legs/hands
___Wheezing

Gastro-Intestinal

___Belching or Gas
___Colon trouble
___Constipation
___Diarrhea
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Poor digestion
___Vomiting
___Vomiting blood

Eye/Ear/Nose/Throat

___Asthma
___Crossed eyes
___Deafness
___Earache
___Ear discharge
___Enlarged thyroid
___Frequent colds
___Hay fever
___Hoarseness
___Nasal obstruction
___Nose bleeds
___Eye pain
___Poor vision
___Sinusitis
___Sore throats
___Tonsillitis

Respiratory

___Chest pain
___Chronic cough
___Difficulty Breathing
___Spitting blood
___Spitting phlegm

Cardio-Vascular

___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Previous heart trouble
___Rapid heart
___Slow heart
___Strokes
___Swelling ankles
___Varicose veins

Skin or Allergies

___Boils
___Bruising easily
___Dryness
___Eczema
___Hives or allergy
___Itching
___Sensitive skin
___Skin eruptions

Genito-Urinary

___Bed wetting
___Blood in urine
___Frequent urination
___Inability to control urine
___Kidney infection
___Painful urination
___Prostate problems

For Women Only

___Cramps or backaches
___Excessive flow
___Hot flashes
___Irregular cycles
___Miscarriage
___Painful periods
___Vaginal dryness
___Pregnant at this time
___Last PAP date___/___/___
By Whom_____

Signature _____ Date: ___/___/___

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Phone: (513) 385-2273
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HIPPA PRIVACY POLICY

The following is to inform you of the privacy policy we uphold within this practice. For your convenience, this is a condensed version of the privacy policy. If you would like to review the privacy policy in its entirety, it will be made available to you upon request.

*Protected health information (PHI) includes information about your health condition as well as the treatment that you receive from our practice. PHI is often referred to as your health care or medical record.

*Our practice will never disclose your PHI to outside sources for any reason other than a request for medical records, review of medical services for a third party, or for billing services.

We are authorized to provide your PHI to a business associate (BA). A BA is a separate entity that assists our practice in some type of essential function, such as a billing company that assists in the submission of claims for payment to insurance companies, etc.

This notice is effective as of February 2, 2010.

I acknowledge that I have read the above, and understand the agreement and its terms.

Should a family member or friend step into the office or telephone the office, I do ___ do not___ give permission to acknowledge my presence in the office.

_____
(Patient's/Guardian's signature

_____
(Patient's/Guardian's PRINTED name
Date: ____/____/____