Dr.Michael Morea
388 N Third Avenue, Suite L Fruitport MI 49415
P: (231) 865-7474 F: (231) 865-7484

PATIENT INFORMATION

Patient Name ______________________
Prefer to go by ______________________
Address ______________________
City ______________ State ______ Zip ________
Home Phone ______________________
Cell Phone ______________________
Email ______________________
Sex ❑ M ❑ F Age _____ Birthday __________
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered

Employer / School ______________________
Occupation ______________________
Spouse's Name ______________________
Spouse's Employer ______________________
Spouse's Occupation ______________________
Primary Care Physician ______________________
Physician Phone ______________________
Social Security Number ______________________

Who may we thank for referring you? ______________________

HOW CAN WE HELP YOU?

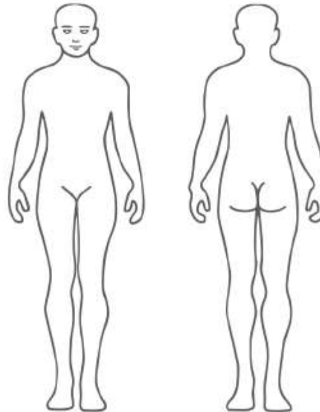
What brings you in today? ______________________

____

If you are already experiencing a symptom, what is it? ______________________

How bad is it? How intense are your symptoms? (circle) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿
NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp
❑ Tingling ❑ Shooting
❑ Stiffness ❑ Burning
❑ Dull ❑ Throbbing
❑ Aching ❑ Stabbing
❑ Cramping ❑ Swelling
❑ Nagging ❑ Other ______________

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other ________	❑	❑	❑	❑

How committed are you to correcting this issue? ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿
NOT COMMITTED — VERY COMMITTED

Health & Illness History

Please circle any condition(s) you have or have had. Please circle S for Self or F for Family History.

S F AIDS/HIV
S F Alcoholism
S F Anxiety
S F Arteriosclerosis
S F Arthritis
S F Asthma/Allergies
S F Back Pain
S F Cardiovascular Issues
S F Childhood Disease
S F Depression
S F Diabetes
S F Digestive Issues
S F Cancer ______________

S F Circulation Issues
S F Endocrine Issues (thyroid)
S F Eye Issues (floaters)
S F Foot/Ankle Issues
S F Gout
S F Headaches/Migraines
S F Heart Disease
S F Hepatitis
S F Hip Issues
S F Immune Issues
S F Lymphatic Issues
S F Multiple Sclerosis
S F Neck Pain

S F Reproductive Issues
S F Ringing in Ears
S F Shoulder Issues
S F Stroke
S F TMJ Issues
S F Urinary Issues
S F Osteoporosis

Other Conditions or Surgeries:

____

____

____

____

____

CHILDREN & PREGNANCY

How many children do you have? ____________________________

Childrens' names and ages ________________________________

Childrens' health concerns? _________________________________

Are you currently pregnant? ❑ No ❑ Yes, I am due ________

Number of past pregnancies? ________________________________

Health concerns regarding this pregnancy? ____________________

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

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____

____

MEDICATIONS (list)

____

____

____

____

____

SUPPLEMENTS (list)

____

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____

____

____

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HIPPA PRIVACY PRACTICES

I acknowledge that Morea Chiropratic Wellness Center, PLC "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Morea Chiropratic Wellness Center's Notice of Private Practices prior to signing this document. The 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 healthcare operations at Morea Chiropratic Wellness Center.

The Notice of Privacy Practice is also posted on our website at www.moreachiro.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Morea Chiropratic Wellness Center, duties with respect to my protected health information. LMorea Chiropratic Wellness Center, 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 by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

____

____

PRIVACY & COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

❒ Text - Cell phone number______________________Cell phone provider______________________

❒ Phone – number ____

❒ Work phone ____

Email communication: ❒ I give my permission to send occasional emails with birthday gifts, news, specials, and events.

(We will not sell or give your address to third parties)

INFORMED CONSENT

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. **If you have already experienced a stroke, an approval to receive chiropractic care must be signed by your primary care physician.** The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

____

Print Name ***Signature*** ***Date***

****

Consent to evaluate and adjust a minor child:

I, ______________________ being the parent or legal guardian of ___________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

____

Name Patient Representation (parent, guardian) ***Signature*** ***Date***

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ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the Morea Chiropratic Wellness Center, Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.moreachiro.com It is also provided upon request at the main administration desk.

I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

Upon placement of your delinquent account with a third party collector (eg. collection agency or collection law firm), you will be responsible for and your account will be assessed, a collection fee in the amount of 33.33% of the then outstanding balance.

My signature also authorizes the payment be made directly to Morea Chiropratic Wellness Center for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

Morea Chiropratic Wellness Center reserves the right to transfer account credits within a family to settle balances due.

I understand and agree that Morea Chiropratic Wellness Center has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of Morea Chiropratic Wellness Center to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ ______________________________

Signature of Patient/ Patient Representative **Date**

Acknowledgement of Special Promotion

I acknowledge that the discount with (coupon / referral card / other: __________________) is a special promotion at Morea Chiropractic Wellness Center designed to allow me to receive care only at Morea Chiropractic Wellness Center.
As such, I understand that upon my request for records, either for my own person use or any other doctor, hospital, person or institution, I will be charged the full usual and customary fees for the services I originally received at a discounted rate. I expect to receive no further notice of this policy.

Name (print) ____ Date ______________________________

Signature ____ Witness ____________________________