PATIENT CONFIDENTIALITY FORM

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. PLEASE PROVIDE US WITH THE FOLLOWING:

Patient Information

Date: _____

Name: _____ **Social Security No.: _____**

Address: _____ **City/State/Zip: _____**

Home Phone: _____ _____ **Work Phone:_____** **Cell Phone: _____**

Email: _____ **Date of Birth: _____** **Age:_____**

Sex: Male / Female Marital Status: Married / Single / Divorced / Widowed Employer:_____

Spouses Name:_____ **Spouses Employer: _____**

Children(s) Ages:_____ **Are you pregnant? ☐ Yes / ☐ No**

Emergency Contact: _____ **Relationship:_____** **Phone: _____**

Who or What Source Referred You:_____

Ethnicity: Hispanic or Latino/Other Preferred Language: _____

Race: Asian / African Am. Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never Education : High School / Some College /College Grad / Graduate School

Primary Care Physician: _____ **Doctor's Phone: _____**

Who is responsible for payment? Self / Spouse / Other Ins. Company: _____
If Other, please explain: _____

History or Current Condition

Is this Appt. related to a Work Comp. or Personal Injury Case? ☐Yes / ☐No

Major Complaint(s): ☐ Neck ☐ Upper-Back ☐ Mid-Back ☐ Low Back ☐ Other:_____
How did it start?_____
Previous History of Complaint ☐ Yes / ☐ No When Did it start: _____

Have you received any other treatment for this current condition? None / DC / MD / PT / Massage / Other: _____

Where? _____

How would you Rate your Pain? ☐ Mild (2 3 4) ☐ Mod (5 6) ☐ Sev (7 8 9) Is the Pain: ☐ Constant ☐ Intermittent
Type of Discomfort: ☐ Sharp ☐ Stabbing ☐ Burning ☐ Achy ☐ Dull ☐ Stiff & Sore ☐ Numbness/Tingling
Radiating: ☐ Y ☐ N ☐Left/☐Right ☐Base of Skull ☐Shoulder ☐Arm ☐Hand ☐Hip ☐Leg ☐Knee ☐Foot ☐Ribs Other:_____
What Makes it Better? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Stretching ☐ OTC ☐ Prescription Other:_____
What Makes it Worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Sleep ☐ Overuse Other: _____
Activities of Daily Living affected by Health Complaint:

_____

Does Your Pain Awaken you at night? ☐ Yes / ☐ No Describe:_____
Have You Noticed any Changes in Bodily Function [Urination, Defecation, Respiration, Digestion, Vision, Sexual, other] since the onset of your complaint? ☐ Yes / ☐ No Describe:_____
Had any diagnostic testing? X-rays / MRI / CT / Other: _____

Are you taking any medication? ☐ Yes / ☐ No OTC/ Prescriptions _____

Allergies to Medications? ☐ Yes / ☐ No _____

Have you had any surgeries? ☐ Yes / ☐ No Please Explain: _____

Have you Broken any Bones? ☐ Yes / ☐ No Please Explain: _____

Have you had any new falls or accidents? ☐ Yes / ☐ No Date of fall or accident: _____

Please explain in detail how the fall or accident happened:_____

_____

Additional patient comments:_____

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Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic 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 chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree the 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 for professional services rendered to me will be immediately due and payable.

Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he/she deems necessary in my care; and further authorize him/her to disclose all or any of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including and not limited to, hospital or medical service companies, insurance companies, workers compensation carrier, welfare funds or the patient's employer.

By signing below, I authorize Wills Chiropractic Clinic, P.C., 1335 M Street, Gering, NE 69341, to obtain and/or disclose my medical records, imaging reports, or any chiropractic/medical imaging. I understand that this authorization may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosure occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be subject to protection as protected health information.

Patient Signature: _____

Parent or Guardian's Signature: _____

Internal Use Only

☐ NP ☐ New Incident ☐ Re-Exam

Patients Appearance/Mood: ☐ Distress ☐ Mild ☐ Moderate ☐ Severe

Nourished: ☐ Well ☐ Obese ☐ Morbid

Other_____

Additional Info: _____

_____

X-RAY ORDERED:

Cervical	Thoracic	Lumbar
☐ 3 Views	☐ 2 Views	☐ 2 Views
☐ 5 Views	☐ 4 Views	☐ 4 Views
☐ 7 Views	☐ Flex / Ext	☐ Flex / Ext.
☐ Oblique's		☐ Oblique's
☐ Flex/Ext		☐ AP Spot

Other: ☐ R ☐ L ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ R ☐ L ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

_____

VITALS:

HGT: _____

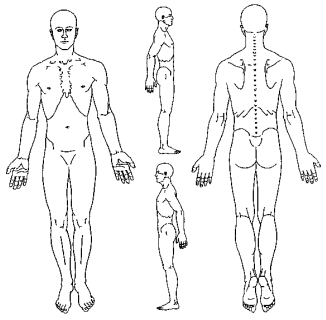
WGT: _____

BP: _____

Pulse: _____

TREATMENT:

Exam M A DJ X LLL



H	__	Hypoesthesia	T	__	Tenderness upon palpation
N	__	Numb			
P	__	Pain	S	__	Spasm

Wills Chiropractic Clinic PC
1335 M St., Gering, NE 69341
created 12/1/15

CA_____DR_____