

Patient Data**Date:**Title: Mr. Mrs. Ms Miss (check one)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Date of Birth: ____/____/____ Sex: Male Female Height _____ Weight _____Social Security Number: _____ - _____ - _____ Marital Status: Single Married OtherEmployment Status: Employed Unemployed Full Time Student Part Time Student OtherDo you have a family member that is a patient in the clinic? Yes No Relationship: _____**Insurance Data**Relationship to primary insurance policy holder: Self Spouse Parent Other:

If other than Self, please provide policy holder:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth ____/____/____ Social Security Number: _____ - _____ - _____

Employer Data

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Contact Name: _____ Contact Phone: (_____) _____ - _____

Primary Care Physician

Name: _____ Contact Phone: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet Website | <input type="checkbox"/> Health Class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper Ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct Mail Ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on Building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other: |

If you selected 'Family Member', 'Friend', or 'Physician' please enter their name below:

If you selected 'Internet Website' please describe:

Are You Here For: (check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Nutritional Consult | <input type="checkbox"/> Maintenance Care |
| <input type="checkbox"/> Other: | | | |

Medical Conditions:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Abnormal Weight Gain/Loss | <input type="checkbox"/> Fever | <input type="checkbox"/> Corticosteroid Use |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Aortic Aneurism | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Blood Thinning Medications | <input type="checkbox"/> Other: | | |

Surgeries:

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular Procedure | <input type="checkbox"/> Cervical/Lumbar Procedure | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Other: | | | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Other: | | |

Family History:

- | | | | |
|---|--------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Other: | <input type="checkbox"/> | |

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |
| <input type="checkbox"/> Other: | | | |

In general, would you say your overall health right now is:

- | | | | |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Poor | | | |

Are you taking any nutritional supplements/vitamins?

- Yes No

If so, please name them:

Who have you seen for your current symptoms?

- | | | | |
|-----------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> No one | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Surgeon: | <input type="checkbox"/> Other: | | |

Protecting Your Confidential Health Information is Important to Us

For Law Enforcement:

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of crime or in order to report a crime.

Family, Friends and Caregivers:

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners:

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research:

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional review board.

Authorization to Use or Disclose health Information:

Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgement:

Patient Name(s) **Print:**

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

X

Patient (or Parent/Guardian) Signature

Date: ____/____/____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions:

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications:

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your health Information:

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information:

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records containing your health information are determined to be accurate and complete.

Documentation of Health Information:

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice:

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

