Advantage Chiropractic & Rehabilitation

WELCOME

OPTIMUM HEALTH THROUGH CHIROPRACTIC & REHABILITATION

Patient Information:

Thank You for choosing our practice for your needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_______________________________________ Date_____________ SS# xxx-xx-__________

Address__________________________________ City________________ State_____ Zip__________

Birth date________________ Home phone #__________________ Work phone #__________________

E-mail ____ Driver's License #____________________

Do you prefer to receive calls at: ☐ Home? ☐ Work? ☐ Either?

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Employer____ Occupation_____________________

Business address___________________________ City________________ State_____ Zip__________

Spouse's or parent's name_______________________________________ Phone #__________________

Spouse's Employer____ Work phone #________________

Emergency Contact____ Phone #___________________

Insurance Information:

Name of Insured_____________________________________ Relationship to patient________________

Address_______________________________________ City________________ State_____ Zip_________

Name of employer____ Work Phone #__________________

If your symptoms are not due to an auto or work injury and you would like us to bill your health insurance, please give the receptionist your insurance card to copy so we may verify your coverage.

Auto or Work Injury:

If your symptoms are due to a recent auto or work injury, please ask receptionist for accident forms.

Outcomes Assessments:

Third Party payers require us to document how your symptoms are affecting your daily activities. Please let the receptionist know your primary area(s) of complaint so that you may be given the appropriate forms to document this.

CONFIDENTIAL

Health History:

❑ AIDS/HIV	❑ Depression	❑ Liver Disease	❑ Rheumatoid Arthritis
❑ Alcoholism	❑ Diabetes	❑ Measles	❑ Scarlet Fever
❑ Allergy	❑ Emphysema	❑ Migraine Headaches	❑ Stroke
❑ Anemia	❑ Epilepsy	❑ Miscarriage	❑ Suicide Attempt
❑ Anorexia	❑ Fractures	❑ Mononucleosis	❑ Thyroid Problems
❑ Appendicitis	❑ Glaucoma	❑ Multiple Sclerosis	❑ Tonsillitis
❑ Arthritis	❑ Goiter	❑ Mumps	❑ Tuberculosis
❑ Asthma	❑ Gonorrhea	❑ Osteoporosis	❑ Tumors, Growths
❑ Bleeding Disorders	❑ Gout	❑ Pacemaker	❑ Typhoid Fever
❑ Breast Lump	❑ Heart Disease	❑ Parkinson's Disease	❑ Ulcers
❑ Bronchitis	❑ Hepatitis	❑ Pinched Nerve	❑ Vaginal Disease
❑ Bulimia	❑ Hernia	❑ Pneumonia	❑ Whooping Cough
❑ Cancer	❑ Herniated Disc	❑ Polio	❑ Hypertension
❑ Cataracts	❑ Herpes	❑ Prostate Problems	❑ Other______________
❑ Chemical Dependency	❑ High Cholesterol	❑ Prosthesis	______________
❑ Chicken Pox	❑ Kidney Disease	❑ Psychiatric Care	______________

Daily Habits:

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

____

What vitamins do you currently take?______________________________________

What kind of other nutritional supplements do you take (if any)?______________________

Do you smoke? ☐ No ☐ Yes How much per day? ______________________

How much liquor do you consume on a weekly basis?______________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Advantage Chiropractic & Rehabilitation (A.C. & S.C., P.C.) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to A.C. & S.C., P.C. insurance benefits otherwise payable to me. ***I understand that my health insurance carrier may pay less than the actual bill for services. I further understand that insurance benefits that are quoted to Advantage Chiropractic & Rehabilitation by my insurance carrier are not a guarantee of payment and I understand that I should check my insurance benefits as well to verify coverage. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*** *I understand that if my account becomes delinquent 60 days or more, the account may be handled by a collection agency and a collection fee will be added to the account. In event of default, for any reason, I will be responsible for any and all attorney fees, court costs, and collection fees. I hereby authorize the Doctor to treat my condition through use of manipulation and/or mobilization throughout my spine, as well as therapeutic procedures, as they deem appropriate.*

Patient's Signature ______________________________ Date ________________

Advantage Chiropractic & Rehabilitation

ACKNOWLEDGEMENT
RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have been notified of the Advantage Chiropractic & Rehabilitation Notice of Privacy Practices.

______________________________________ ____________
Signature of Patient or Patient Representative Date

____
Relationship to Patient

HIPAA Authorization to Release Medical Information

Due to HIPAA Regulations and our promise to provide you with the utmost privacy, this HIPAA Authorization to Release Medical Information Form is designed to allow only certain people whom you select to have access to your medical information.
<u>For example: your spouse, children, or family friend (this form only pertains to family and friends.)</u>

I hereby authorize the following people to have access to my medical information: (This includes but is not limited to: sitting in during my consultations with the physician, and calling the office to check my medical status. This authorization will hold in effect until I submit a written notice of any changes.)

Name	Relationship	Authorization Date	Date Authorization Revoked
1.			
2.			
3.			
4.			

Patient Signature: ______________________________ Date: ____________