

Welcome

1

About you

2

Insurance Info

TODAY'S DATE: ____ / ____ / ____ FILE # ____

PATIENT NAME: _____

LAST FIRST MI

WHAT YOU PREFER TO BE CALLED _____ ☐ MALE ☐ FEMALE

BIRTHDATE: ____ AGE ____ SS# ____

MAILING ADDRESS: _____

CITY STATE ZIP

HOME PHONE #: _____

WORK PHONE #: _____ EXT _____

CELL PHONE #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ HOW LONG? ____

EMPLOYERS ADDRESS: _____

CITY STATE ZIP

OCCUPATION: _____

STATUS: MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSES NAME: _____

DO YOU HAVE KIDS? YES NO HOW MANY ____

CO. NAME: _____

ADDRESS: _____

PHONE#: _____

INSURED'S SS#: _____

GROUP# (PLAN, LOCAL OR POLICY#)

INSURED'S NAME: _____

RELATION: _____

DATE OF BIRTH ____ / ____ / ____

INSURED'S EMPLOYER: _____

PLEASE INFORM FRONT DESK OF 2ND. INSURANCE
SOURCE

3

REASON FOR VISIT

THE REASON FOR THIS VISIT IS A RESULT OF: (PLEASE CIRCLE): WORK SPORT AUTO TRAUMA OR CHRONIC

(EXPLAIN WHAT HAPPENED): _____

PLEASE DESCRIBE THE PAIN & ITS LOCATION : _____

WHEN DID THIS CONDITION BEGIN? ____ / ____ / ____

IS THIS CONDITION GETTING WORSE?

YES NO CONSTANT COMES & GOES

IS THIS CONDITION INTERFERING WITH YOUR: (PLEASE CIRCLE) WORK SLEEP OR DAILY ROUTINE

IF SO PLEASE EXPLAIN : _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR THIS CONDITION? YES NO

IF SO WHERE ? _____

4

IN EVENT OF EMERGENCY

Who should we contact? : _____

Relation : _____

Home phone# : _____ Work phone# : _____

Who is your Medical Doctor? _____ phone# : _____

5

HEALTH HISTORY

Are you taking any of the following medications?

- ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin
☐ Others _____

Do you have or ever had any of the following diseases or conditions?

- | | | | | | |
|--------------------------------|---------------------------|-----------------------|-------------------------|------------------------|-------------------------------|
| Y N Heart Attack | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Dizziness | Y N Jaw Problems | Y N Leg pain |
| Y N Congenital Heart Defect | Y N Mitral valve Prolapse | Y N Artificial Valves | Y N Difficulty sleeping | Y N Irritability | Y N Ears ringing |
| Y N Alcohol/Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N Nausea | Y N Back pain | Y N Stomach upset |
| Y N HIV+/ Aids | Y N Shingles | Y N Cancer | Y N Arm/Shoulder pain | Y N Headaches | Y N Numb Feet/Toes |
| Y N Frequent Neck Pain | Y N Emphysema / Glaucoma | Y N Anemia | Y N Fatigue | Y N Numb Hands/Fingers | Y N Neck pain |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Blurred vision | Y N Lower back pain | Y N Memory loss |
| Y N Severe Frequent Headaches | Y N Kidney Problems | Y N Ulcers / Colitis | Y N Back stiffness | Y N Tension | Y N Arthritis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus problems | Y N Asthma | Y N Shortness of breath | Y N Chest pain | Y N Artificial Bones / Joints |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy | Y N Neck stiff | Y N Buzzing in ear | Y N Lower Back Problems |

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries / treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

Do you: Take supplements or vitamins? ☐ Yes ☐ No / Exercise ☐ Yes ☐ No

Are you on a special diet ☐ Yes ☐ No / Since _____ / _____ / _____

Do you Smoke? ☐ Yes ☐ No / How much _____ How long _____

Are you wearing Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

For women:

Are you taking Birth Control? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes / How Long?

Nursing? ☐ Yes ☐ No

■ I AGREE TO PAY FOR SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS THE CHARGES ARE INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NON-COVERED. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE. THE INJURIES / ILLNESS SUSTAINED AND THE PAIN AND SUFFERING I HAVE ARE REAL AND I HAVE NOT EITHER IMAGINED OR EXAGGERATED THE EXTENT AND NATURE OF MY PAIN AND SUFFERING OR ILLNESS.

■ I AM OF SOUND MIND, AND TO THE BEST OF MY KNOWLEDGE ALL THE INFORMATION I HAVE PRESENTED IS TRUE.

I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS

AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER AND OR MANAGED CARE ORGANIZATION, TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

SIGNATURE _____

PAIN CHART

About you

PATIENT NAME: _____ FILE # _____

WHAT IS YOUR CURRENT WEIGHT: _____ LBS, AND HEIGHT _____ Ft _____ IN.

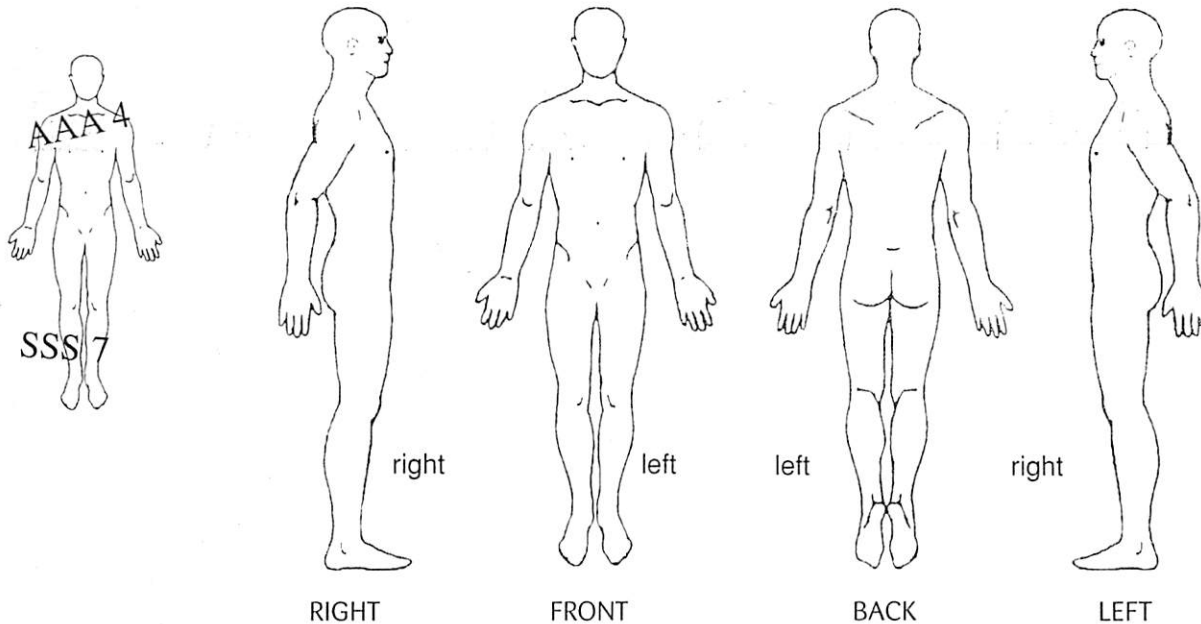
PLEASE DESCRIBE YOUR CONDITION: _____

SIGNATURE _____ DATE _____

Show us where it hurts

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS SHOWN IN THE EXAMPLE BELOW. MARK ALL AREAS WITH THE APPROPRIATE SYMBOLS AND INDICATE THE DEGREE OF PAIN USING A SCALE: FROM 1 (DISCOMFORT) TO 10 (EXTREME PAIN).

DESCRIPTION	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
SYMBOL	NNN	PPPP	BBBB	AAAA	SSSS



Doctors Notes

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

ACCIDENT, PRIVATE AND GROUP HEALTH INSURANCE

I hereby direct and instruct the _____ Insurance Company to pay by check made out and mailed directly to:

INJURY RELIEF CHIROPRACTIC

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

INJURY RELIEF CHIROPRACTC

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentiones assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above the insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authoorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney invoved in this case.

DATED AT Injury Relief Chiropractic THIS _____ DAY OF _____

SIGNATURE OF POLICYHOLDER

WITNESS

SIGNATURE OF CLAIMANT, IF OTHER THEN POLICYHOLDER

HEALTH CARE AUTHORIZATION FORM

Name _____

SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES DR. EVELYN FLEMONS, INJURY RELIEF CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING

SPECIFIC AUTHORIZATION (please circle all that apply)

- I give permission to Injury Relief Chiropractic, to use my address, phone number, and clinical records to contact me with appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information. I also give permission allowing my name to be posted on a referral board or my picture to be posted on message board for office related events. In the future should I write a testimonial regarding my treatment in this office, I give permission for it to be posted.
- If Injury Relief Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail, or with the individual who answers the telephone.
- I give Injury Relief Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Injury Relief Chiropractic, permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Injury Relief Chiropractic. The written notice must contain the following information:

Your social security number and date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Injury Relief Chiropractic, for its own use/disclosure of Protected Health Information. (Minimum standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Injury Relief Chiropractic, will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

**** ** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU** ****

Print name of Patient _____

Signature _____

Date _____

Signature of Personal Representative _____