Family Chiropractic Case History/Patient Information

Name:_____ Email Address_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ Social Security #_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D How many children?_____

Occupation:_____ Employer:_____

Employer's Address:_____ WorkPhone:_____

Spouse:_____ Occupation:_____ Employer:_____

Name of Emergency Contact :_____ Phone:_____

How were you referred to our office?_____

Your Medical Doctor:_____

May we have your permission to update your medical doctor regarding your care at this office?_____

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? Yes No

describe:_____

Days lost from work:_____ Date of last physical examination:_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? (include dates):_____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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