FIRST CHIROPRACTIC

Patient Information

Name: _____ Date: _____
Last First Middle Initial

Address: _____ Social Security #: _____

City: _____ E-Mail: _____

State: _____ Zip: _____ Sex: ☐ Male ☐ Female Age: _____

Birthdate: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced No. of Children _____

Occupation: _____ Patient Employer / School: _____

Employer / School Address: _____
Street City St. Zip

Employer / School Phone: _____ Spouse's Name: _____

Spouse's Birthdate: _____ Spouse's S.S. # _____

Spouse's Employer: _____

How were you referred to First Chiropractic? _____

Insurance

Insurance Co.: _____ Insured's Name: _____

Insured's S.S. # _____ Insured's Birthdate: _____

Insured's Employer: _____ Group #: _____

Is patient covered by additional (secondary) insurance? ☐ Yes ☐ No If Yes, please continue this section. If No, please skip to the next section

Secondary Insured's Birthdate: _____ S. S. # _____ Relationship to patient: _____

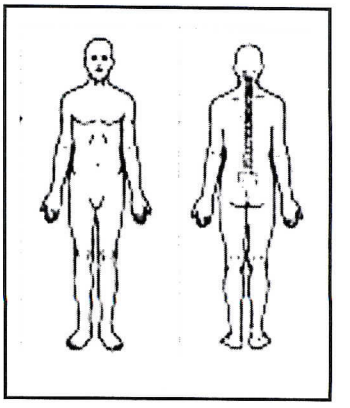
Insurance Co.: _____ Group # _____

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture (to the right) where you continue to have pain, numbness or tingling.



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

On a scale of 1-10, how do you feel now? (1being best, 10 being worst)

1 2 3 4 5 6 7 8 9 10

History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of Primary Care Physician (M.D.) _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a check mark to indicate if you have had any of the following:

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

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Phone Numbers

Home Phone: ( ) _____

Cell Phone: ( ) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY , CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date: _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Workers Comp

☐ Other

Attorney Name (if applicable)

_____

Authorization & Assignment

I authorize First Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe to you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from my insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint First Chiropractic authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered 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 me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at First Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of First Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist

Specific Risk Possibilities Associated with Chiropractic Care:
Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon or other soft-tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke: Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date: _____ Patient's Signature: _____

Witness: _____

FIRST CHIROPRACTIC

GREG A. HIXON D.C.

Notice of Privacy Practices

To obtain more information about your privacy rights or if you have any questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b) (2) (vii)), you may contact the Practice's Privacy Officer as follows:

GREG A. HIXON D.C.
1108 N. BECHTLE AVE.
SPRINGFIELD OH 45504
(937) 328-3220

PRACTICE'S REQUIRMENTS

The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Adheres to Ohio law in those instances where Ohio law does not conflict with federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 08/01/2003.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge this Practices' six page Notice of Privacy Practices, and my understanding and my agreement to its terms.

_____ _____

Patient Date

FIRST CHIROPRACTIC

Medication List

Name: _____ Date: _____

List of medications currently taking

1

2

3

4

5

6

7

8

Alergies to medications: _____

List of vitamins/supplements currently taking:

1

2

3

4

List of past surgeries & approximate dates:

1

2

3

4