

WELCOME

Patient Information

Date _____ / _____ / _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ / _____ / _____

Single Married Widowed Separated Divorced

Patient Social Security Number _____

Occupation _____

Employer _____

Employer Phone _____

Children's Name(s)/Age _____

E-Mail: _____

Whom may we thank for referring you? _____

Have you ever received treatment by a Chiropractor before? Yes No

If yes, when and who? _____

Primary Care Physician _____

May we send the doctor a report? Yes No

Insurance

Insurance Company _____

Subscriber's Name _____

Birthdate _____ / _____ / _____ SS# _____

ASSIGNMENT AND RELEASE:
 I hereby direct any and all insurance carriers, attorneys, and individuals to directly pay Reynoldsburg Chiropractic Center for charges incurred by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Phone Numbers

Home _____ Work _____ Ext _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

HIPAA NOTICE

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 _____ Date _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

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

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

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



