CONFIDENTIAL PATIENT INFORMATION

Date:____________________

Full Name:____ Social Security#: _________________

Address:____City:_____________________ State:_______

Zip:____________ E-mail address:____

Home Phone: ___________________ Cell Phone:__________________________

Date of Birth:____________ Age:___________ Male:____ Female:____ Marital Status: M S W D

Employer's Name:__________________________________ Occupation:______________________

Employer's Address:______________________________________ Office Phone:_________________

Contact Preference: Home_____ Work_____ Cell_____ Email_____ Mail_____

Who does patient reside with?:__________________________

Spouse's Name:____________________ How many children do you have?____________

How were you referred to our office? ____

Family Medical Doctor:____

Language: English_____ Spanish_____ Indian_____ Japanese_____ Chinese____
Korean_____ French_____ German_____ Russian_____ Other_____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____ Decline to Answer_____
French_____ Unknown_____

INSURANCE INFORMATION

We will make a copy of your insurance card(s). However, please complete the following information.

Relationship to Insured: Self Spouse Child Other

Policy Holder's Full Name:____

Policy Holder's Address:____

Policy Holder's Date of Birth: ________________________

Policy Holder's SS#: ____

Policy Holder's Employer: ____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:______________________________

How did it originally occur?______________________________

Is this due to: Auto___ Work____ Other_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

Date symptoms appeared or accident happened:______________________________

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other ______________________________

Is there anything you can do to relieve the problem? Yes ___ No ___

If yes, describe ______________________________

What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

Lifting _____ Twisting _____ Other ______________________________

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

If yes, when and describe:______________________________

Have you ever been to a chiropractor?: Yes No

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes _____ No _____ Uncertain _____

PAST MEDICAL HISTORY

Do you have a history of stroke or high blood pressure?______________________________

Have you ever been diagnosed with diabetes? Type I_____ or Type II_____ If yes, include date & provider seen:______________________________

Have you been hospitalized or had any surgeries, major illnesses, injuries falls or auto accidents? Women, please include information about childbirth:

____

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?______________________________

____

Do you have any allergies to any medications, food or environmental?

List type of allergy and reaction:______________________________

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

General
__Fatigue
__Weakness
__Fever
__Chills
__Weight Change
__Night Sweats

Skin
__Rash
__Redness
__Itching
__Eczema
__Hair Changes
__Nail Changes

Neurologic
__Fainting
__Headache
__Dizziness
__Convulsions

Eyes
__Vision Trouble
__Pain
__Discharge

Ears
__Hearing Trouble
__Ringing
__Pain
__Discharge

Nose
__Pain
__Bleeding
__Absence of Smell

Mouth/Throat
__Absence of Taste
__Abnormal Taste
__Sores
__Bleeding

Heart/Lungs
__Blue Extremities
__Murmur
__Chest Pain
__Palpitations
__Cough
__Wheezing
__Difficulty Breathing
__Swollen Extremities

Breasts
__Lumps in Breast(s)
__Redness/Itching
__Pain
__Dimpling
__Discharge

Stomach/Intestines
__Decreased Appetite
__Increased Appetite
__Abdominal Pain
__Vomiting
__Diarrhea
__Constipation

Reproductive/Urination
__Inability To Hold Urine
__Painful Urination
__Frequent Urination
__Irregular Menstruation
__Painful Menstruation
__Abnormal Vaginal Bleeding
__Impotence
__Sterility

Glandular
__Heat/Cold Intolerance
__Sugar in Urine
__Goiter
__Tremor

Mental
__Anxiety
__Depression
__Memory Loss or Impairment
__Phobias
__Mood Swings

SOCIAL HISTORY:
Do you drink alcoholic beverages?___ If so, how much per week?________________________
Do you smoke? Never_____ Former Smoker_____ Current/Every Day Smoker_____ Current Some Day Smoker_____
Do you take vitamin supplements? If so, please list:____________________________________
Do you consume caffeine?_____ If so, how much per day:________________________________
Do you exercise?__________ If yes, what is the frequency and type of exercise?__________________________
Do you use recreational drugs? ____________________

FAMILY HISTORY:
Parents:
Father: living___ deceased____ Cause of death if deceased:____________________
Mother: living___ deceased____ Cause of death if deceased:____________________
FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):
Cancer____ Mental Illness____
Diabetes ____ Asthma____ Heart Disease ____
Stroke ____ Kidney Disease____ Lung Disease____
Arthritis_____ Liver Disease ____
Other ____

AUTHORIZATION:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment.

B. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me 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 or products or professional services rendered will be immediately due and payable.

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bratcher Injury & Wellness Center, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____

Name of Patient (print)

____

Signature of Patient or Patient Representative **Date**