midtown
chiropractic & acupuncture

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Social Security Number (last 4 digits) _____ Birth Date: ____/____/____ Age: ____ Gender: M F

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Email Address _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

Your Occupation _____ Student ☐ FULL-TIME ☐ PART-TIME

Name of Spouse/ Partner _____ Spouse's Date of Birth ___/___/____

Who should we contact in the event of an emergency? _____ Phone (____) _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

How did you learn about us? _____

Approximately, when did your injury or condition occur? ____/____/_____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

What caused it?

_____

What aggravates it?

_____

What relieves it?

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Have you ever suffered from:

☐ Dizziness
☐ Backaches
☐ Heart Trouble
☐ Diabetes
☐ Neuritis
☐ Arthritis
☐ Headaches
☐ Numbness
☐ Asthma
☐ Cancer
☐ Digestive Disorders
☐ Nervousness
☐ Sinus Trouble

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

3) _____ ___/___/___

What medications or drugs are you taking?

_____

_____

Surgeries/Hospitalizations:

_____

_____

Serious illnesses or conditions?

_____

_____

Allergies (please list all):

_____

_____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems
☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Other: _____

CONSENT FOR TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on a minor in my care.

by the licensed doctors of chiropractic, and/or certified assistants who may be employed by or engaged in practice in this clinic. I will have an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interests.

By signing, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient/Guardian Signature_____ Patient Name_____

Date ____/_____/_____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

PRIVACY NOTICE

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and ACKNOWLEDGEMENT OF RECEIPT OF A COPY OF OUR PATIENTS RIGHTS AND PATIENT RESPONSIBILITIES POLICIES.

I acknowledge that a copy of Midtown Chiropractic & Acupuncture's Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I FURTHER Acknowledge that I have received a copy of Midtown Chiropractic & Acupuncture's Patient Rights and Patient Responsibilities Policies.

Signature: _____ Date: ___/___/___