Confidential Patient Information

Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell: _____

Email: _____ Social Security #:_____ Age:_____

Would you like to receive a ☐ text or ☐ e-mail reminder of your appointments? ☐ Yes ☐ No

☐ Male ☐ Female Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Other_____

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

Name of Auto Insurance Co.:_____

List present complaints, injuries and duration:

1. _____

_____

2. _____

_____

3. _____

_____

*Remarks, **dates** and **details** of any accident:*

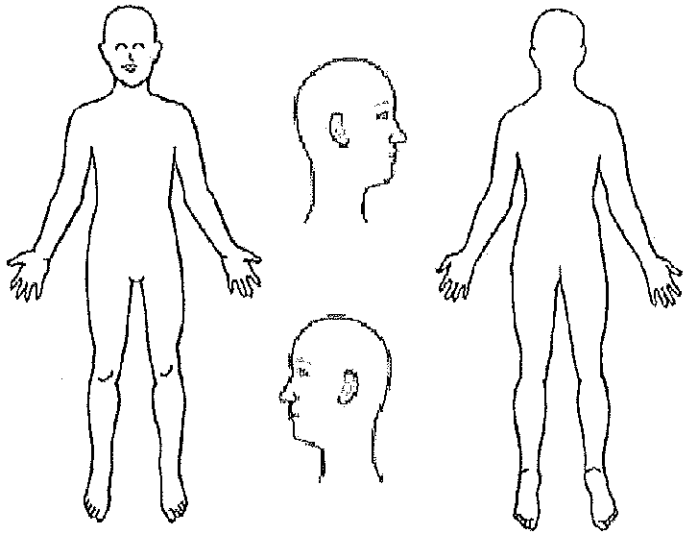
_____

_____

_____

_____

Please mark your area of pain on the figures below:



List other doctors consulted for present complaints and injuries:

Name: _____ When Consulted: _____

Diagnosis: _____ Treatment: _____

How long did you see the Doctor? _____ How frequently: _____

Results: _____

Name: _____ When Consulted: _____

Diagnosis: _____ Treatment: _____

How long did you see the Doctor? _____ How frequently: _____

Results: _____

Present Family Doctor: _____ Date of last physical examination: _____

Patient Name:_____ **Date:** _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F	
☐	☐	☐	Heart Disease
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Back pain
☐	☐	☐	Bladder trouble
☐	☐	☐	Bone fracture
☐	☐	☐	Cancer
☐	☐	☐	Chest pain
☐	☐	☐	Concussion
☐	☐	☐	Convulsions
☐	☐	☐	Diabetes
☐	☐	☐	Indigestion

S	M	F	
☐	☐	☐	Dislocated joints
☐	☐	☐	Epilepsy
☐	☐	☐	Measles
☐	☐	☐	Headaches
☐	☐	☐	Heart trouble
☐	☐	☐	Reproductive disorders
☐	☐	☐	High blood pressure
☐	☐	☐	HIV/ARC
☐	☐	☐	Kidney disorder
☐	☐	☐	Bowel control loss
☐	☐	☐	Menstrual cramps
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Muscular Dystrophy

S	M	F	
☐	☐	☐	Neck pain
☐	☐	☐	Nervousness
☐	☐	☐	Numbness
☐	☐	☐	Polio
☐	☐	☐	Poor circulation
☐	☐	☐	Hepatitis
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Scarlet Fever
☐	☐	☐	Serious injury
☐	☐	☐	Sinus trouble
☐	☐	☐	Stroke
☐	☐	☐	Tuberculosis
☐	☐	☐	Venereal disease

Do you smoke? Yes ____ No ____ If so, how many packs per day? _____

Do you drink alcohol? Yes ____ No ____ If yes, how often and how much? _____

Do you use Illicit drugs? Yes ____ No ____ If yes, describe: _____

_____

What surgeries have you had?

Type/When/Doctor/Remarks: _____

_____

_____

List former serious accidents and falls: (***circle one*** ~ auto, work, home, leisure, sports, other)

What/When/Symptoms/Treatment/Results: _____

_____

_____

List broken bones:

What/When/Remarks: _____

_____

_____

List ***Medications*** and/or ***diet supplements*** you take and any ***Allergies***:

What/Frequency/Doctors/Side Effects/Allergies/Remarks: _____

_____

_____

_____

_____

Environment:

- Work ~ Please circle appropriate answer
- Seated/Standing ~ Work Bench/Desk/Counter/Other: _____
- Job Involves ~ Lifting/Bending/Stooping/Twisting/Carrying/Walking/Standing/Other: _____
- Chair ~ Executive/Steno/Bench/Stool/Folding/Other: _____
- Shoes ~ High heels/Boots/Other: _____

Patient Name:_____ **Date:** _____

Leisure:

- Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe)

_____

- Strenuous activities? Exercise ~ Type/Frequency/Length of time? _____

_____

- Sports ~ Type/Frequency/Length of time? _____

_____

- If you have discontinued sports or strenuous activities, why the change? _____
- Exert Yourself ~ Frequently/Occasionally/Rarely/Never? Describe how: _____

_____

Review of Systems

General
- ☐ Weight Loss or Gain
- ☐ Fatigue
- ☐ Fever or Chills
- ☐ Trouble Sleeping

Skin
- ☐ Rashes/Wounds
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair/Nail changes

Head
- ☐ Headache
- ☐ Head Injury

Ears
- ☐ Trouble Hearing
- ☐ Ear Pain

Eyes
- ☐ Glasses or Contacts
- ☐ Eye Pain
- ☐ Redness
- ☐ Blurry/Double Vision
- ☐ Flashing Lights
- ☐ Seeing Specks

Nose
- ☐ Sinus Pain
- ☐ Nasal Discharge
- ☐ Hay Fever
- ☐ Nose Bleeds
- ☐ Trouble Smelling
- ☐ Post-Nasal Drip

Throat
- ☐ Sore Tongue
- ☐ Sore Throat
- ☐ Hoarse Voice
- ☐ Thrush
- ☐ Non-healing Sores

Neck
- ☐ Lumps
- ☐ Swollen Glands
- ☐ Neck Pain
- ☐ Neck Stiffness

Respiratory
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Painful Breathing

Cardiovascular
- ☐ Chest pain
- ☐ Tightness
- ☐ Palpitations
- ☐ Swelling

Vascular
- ☐ Calf Pain with Walking
- ☐ Leg Cramping

Gastrointestinal
- ☐ Swallowing Difficulties
- ☐ Heartburn
- ☐ Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Yellow Eyes or Skin

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or Pain
- ☐ Blood in Urine
- ☐ Incontinence

Genital
Male
- ☐ Pain with sex
- ☐ Hernia
- ☐ Penile Discharge
- ☐ Penile Sores
- ☐ Lumps or Masses
- ☐ Erectile Dysfunction
- ☐ STD's

Female
- ☐ Pain with Sex
- ☐ Vaginal Dryness
- ☐ Hot Flashes
- ☐ Vaginal Discharge
- ☐ Itching or Rash
- ☐ STD's

Breasts
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self Exams

Musculoskeletal
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Redness of Joints
- ☐ Swelling of Joints
- ☐ Trauma

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors

Hematologic
- ☐ Bleeding Disorder
- ☐ Easy Bruising

Endocrine
- ☐ Hot Intolerant
- ☐ Cold Intolerant
- ☐ Frequent Sweating
- ☐ Frequent Urination
- ☐ Frequent Thirst
- ☐ Frequent Hunger

Psychiatric
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Stress

Patient Name:_____ **Date:** _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to **Complete Family Chiropractic Health Care or Tarpon Spine & Medical Center** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor/practice may use my health care information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Guardian Date

Financial Responsibility Agreement

I, the undersigned, have read and agreed to the following office procedure policies of:
Complete Family Chiropractic Health Care and/or Tarpon Spine & Medical Center.

1. Payment is expected in full as services are rendered unless prior financial arrangements have been made.
2. The patient is responsible for any portion of an insurance claim which is not paid by their insurance company.
3. Patients involved in legal suits are responsible for any portion not paid by their insurance company. In the event of a legal settlement, all medical bills to **Complete Family Chiropractic Health Care and/or Tarpon Spine & Medical Center** shall be paid out of settlement funds and before disbursement of settlement funds.
4. Any outstanding balances of thirty (30) days of age or greater are automatically presented to a collections attorney. A 30% fee is assessed to each account and the patient is responsible for all attorney fees and court fees.
5. Payment plans are available and will be privately discussed between the Doctor/Office Manager and patient upon the patient's request.

Financial Responsibility Statement: I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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, against the Doctor's recommendations, my account balance will be immediately due and payable.

_____ _____

Signature of Patient or Guardian Date

Patient Name:_____ **Date:** _____

Authorization Notice for the Use and Disclosure of Patient's Protected Health Information

1. I am authorizing Complete Family Chiropractic Heath Care or Tarpon Spine & Medical Center and staff to use my name out loud in order to call me back to a room for treatment.
2. I understand that in this practice, open bay adjusting and open bay therapy are used. If at any time I need to speak with the doctor in private, I can make this request and set up a special consultation time with the receptionist.
3. I understand that if the practice intends to use my name for advertising purpose or for testimonial purpose, they must further get my permission.
4. I understand that this authorization is voluntary.
5. I am authorizing Complete Family Chiropractic Health Care or Tarpon Spine & Medical and staff to use and/or disclose my protected health information (PHI) **to Insurance Companies, Lawyers, and Doctors** for all health care delivery purposes, which are known as treatment, payment, and health care operation (TPO).
6. I understand that this office will not receive financial or in-kind compensation in exchange for using or disclosing any of my health information.
7. I understand that I may request a copy of this form at any time for any reason and it will be provided for me.
8. This form and the Notice of Privacy Practices for Protected Health Information were completely read and filled in by me before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and its contents.
9. I further understand that this authorization is valid from today until I ask for a change in this policy in writing.
10. Chiropractic care and medical care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.
    Prior to receiving chiropractic care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

11. By supplying my home phone number, mobile phone number, email address and any other personal contact information. I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results or other communications.

    I also authorize my healthcare provider to disclose to third parties who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I understand and accept there are risks associated with treatment and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. I also understand all of the above procedures used by this office and give my consent to those.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Witness (Office Representative) Date

Patient Name:_____ **Date:** _____

Office Rules and Guidelines

1. I agree to the following appointment schedule. I understand that I will be expected to make up any missed appointments. All missed appointments must be made up within 7 days or there will be a $10 fee if appointment is not made up.

2. I agree to follow all other recommendations made by the doctor(s), including the proper use of rehabilitation equipment, doing my exercises as prescribed, etc.

3. I agree to make a personal financial agreement and promptly fill out all necessary medical, legal, and insurance forms to aid in the timely payment for my care.

4. Our appointment space is very valuable. **There is a $10 fee for all missed appointments**. We prefer a 24 hour notice if you are going to cancel your appointment.

Our office hours are:
Monday, Wednesday and Thursday 8:00 a.m. ~ 6:00 p.m.
Tuesday 9:00 a.m. ~ 6:00 p.m.
Friday 9:00 a.m. ~ 5:00 p.m.
The office is closed every day between 12:00 p.m. ~ 2:00 p.m.

We have a 24 hour answering service that will take your call if needed. If any emergencies arise the staff/doctor will be notified. The staff/doctor will return the call in a timely manner.

5. Please no use of cell phones in the reception area. Please turn them off while in the treatment areas. If you need to make a call we ask that you please make it outside the office.

6. If you are going to bring a guest, please have them check in with the front desk before you receive treatment.

7. Please be polite and courteous to all staff members and patients. Please respect all rehab equipment. We use this to correct your spine and improve your treatment progress.

8. You have the right to deny any treatment that you feel is excessive or unnecessary.

9. We are concerned about the safety of your children. Please observe them at all times.

10. If you have an outstanding balance on your account that is not paid within 90 days we will turn your account over for collections. I understand and agree that all legal fees and/or attorney fees associated with collection will be my responsibility.

11. We file your insurance as a courtesy to you. We will file your claims 3 times and provide follow up on the claims. If your insurance does not pay after 3 filings, the amount will be turned over to you. The balance will be due and it will be your responsibility.

I have read and understood the above guidelines for Complete Family Chiropractic Health Care or Tarpon Spine & Medical Center.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness (Office Representative) Date

Complete Family Chiropractic Health Care
Tarpon Spine & Medical Center

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.
To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the "law of jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone by doctors of chiropractic.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question about outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration of cost, in what we work to maintain as a supporting, open environment.

I, _____, have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness (Office Representative) Date

Allergy Assessment

Name: _____ **Date of Birth:** _____

1. Have you ever been diagnosed with Allergies? ☐ Yes ☐ No

   If yes, please tell when you were diagnosed with which allergies: _____

   _____

2. Are you currently taking or have you within the last year taken any prescribed or over the counter medications for allergies, hay fever or nasal congestion? ☐ Yes ☐ No

   If yes, please list all that apply: _____

   _____

3. Have you ever been diagnosed with asthma? ☐ Yes ☐ No

   If yes, is your doctor currently treating your asthma with medications? ☐ Yes ☐ No

- Please list any medications (this includes inhalers) that apply: _____

_____

Please check any/all of the following symptoms listed below that you experience on numerous occasions throughout the year. Please note, these include seasonal changes. You may not be experiencing these symptoms now, but may experience them regularly during a different season of the year.

___ Stuffy Nose
___ Runny Nose
___ Nasal Congestion
___ Itchy Eyes
___ Watery Eyes
___ Itchy Throat
___ Sore Throat
___ Swollen/Puffy Eyes
___ Cough
___ Post Nasal Drip
___ Headaches
___ Trouble Sleeping
___ Fatigue
___ Skin Rash
___ Hives
___ Itchy Skin (Skin Irritation in general)

Signature: _____ Date: _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Name: _____ **DOB:** _____

Email address: _____@_____.com

CMS requires providers to report both race and ethnicity

Ethnicity (Check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Race (Check one): ☐ White (Caucasian) ☐ Black or African American ☐ American Indian or Alsaka Native
☐ Asian ☐ Hawiian or Pacific Islander ☐ Other ☐ I Decline to Answer

Gender (Check one): ☐ Male ☐ Female

Preferred Language: _____

Smoking Status (Check one):
☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage (i.e. 5mg)	Directions (i.e. once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care)

Patient Signature: _____ **Date:** _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____