Lannert Chiropractic Center

1302 W. Garfield Ave., Ste. B ***Phone: (309) 697-8604***
Bartonville, IL 61607 ***Fax: (309) 697-9298***
Website: ***www.lannertchiropractic.com*** E-Mail: lannertchiro@sbcglobal.net
Providing gentle, effective family care since 1997

Welcome To Our Office

Date _____ Patient # _____ Doctor _____

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Patient Information

Name _____ Social Security # _____ Gender ____

Street Address _____ City _____State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Date Of Birth _____ Marital Status: M S W D Spouse _____ # of Children _____

May we call or email you at work for appointment reminders, etc.? Yes / No

Employer _____ Occupation _____

Employer Address _____ Employer Phone _____

Patient's Work Phone _____ Fax # _____ Work E-mail _____

How were you referred to our office? _____ Family Medical Doctor _____

Emergency Contact Person _____Phone _____ Was this accident related? Yes / No

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Insurance Information

Primary Insurance Co _____ Insured's Name _____ Gender _____

ID# _____ Group # _____SS# _____ DOB _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other _____

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Secondary Insurance Co _____ Insured's Name _____ Gender _____

ID# _____ Group # _____ SS# _____ DOB _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other _____

Lifestyle

EXERCISE	WORK	HOBBIES	
( ) None	**( )Sitting**	_____	**( ) Smoking – Packs Per Day** _____
( ) Moderate	**(Standing**	_____	**( ) Alcohol – Drinks Per Week** _____
( ) Daily	**( )Light Labor**	_____	**( ) Caffeine – Cups Per Day** _____
( )Heavy	**( )Heavy Labor**	_____	**( ) High Stress Level – Why** _____

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Health History

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 mark in the box to indicate if you have had any of the following:

( )AIDS/HIV	( )Alcoholism	( )Allergy Shots	( )Anemia	( )Anorexia	( )Appendicitis
( )Arthritis	( )Asthma	( )Bleeding Disorder	( )Breast Lump	( )Bronchitis	( )Bulimia
( )Cancer	( )Cataracts	( )Chemotherapy	( )Chicken Pox	( )Diabetes	( )Emphysema
( )Epilepsy	( )Fibromyalgia	( )Fractures	( )Glaucoma	( )Goiter	( )Gout
( )Heart Disease	( )Heart Murmur	( )Hepatitis	( )Hernia	( )Herniated Disk	( )Herpes
( )High Cholesterol	( )Hypertension	( )Kidney Disease	( )Liver Disease	( )Measles	( )Migraines
( )Miscarriage	( )Mononucleosis	( )Multiple Sclerosis	( )Mumps	( )Osteoporosis	( )Pacemaker
( )Parkinson's	( )Pinched Nerve	( )Pneumonia	( )Polio	( )Prostate Problem	( )Prosthesis
( )Psychiatric Care	( )Rheumatic Fever	( )Scarlet Fever	( )Shingles	( )Stroke	( )Suicide Attempt
( )Thyroid Problem	( )Tonsilitis	( )Tuberculosis	( )Tumor	( )Ulcers	( )Venereal Disease
( )Whooping Cough	( )Typhoid Fever	( )Vaginal Infection	( )Growths		
( ) Rheumatic Fever	( )Chemical Dependency		( )Other _____		

Injuries/Surgeries You Have Had	**Description**	**Approx. Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications _____
Allergies _____
Supplements _____

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ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with the listed insurance company/companies and assign directly to Lannert Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes 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.

Signature _____ Date _____

RADIOLOGY CONSENT: I understand that Lonny J. Lannert, D.C. may have my radiographs interpreted by Rocky Mountain Chiropractic Radiological Center, certified by the American Chiropractic Board of Radiology. I authorize release of any information concerning my (or my child's) health care, and treatment provided for the purpose of evaluating and administering claims for the insurance benefits.

Signature _____ Date _____

Lannert Chiropractic Patient Health Information Consent Form – HIPAA

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

IMPORTANT: We respect your privacy and will not share any of your patient information (INCLUDING YOUR APPOINTMENT TIMES) with other individuals and/or businesses who are either not covered under the HIPAA Rule or listed by you on the lines below**.** PLEASE LIST ALL INDIVIDUALS (SPOUSE, CHILD, PARENT, EMERGENCY CONTACT PERSON, ETC.) who may access your patient information. Thank you.

_____

_____

_____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

(Printed name)

_____ _____

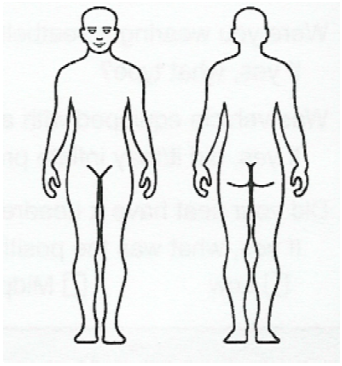
(Signature) (Date)

Patient Consultation Report for Lannert Chiropractic

Patient Name _____ **Date** _____

1. What is your major symptom? _____
2. When did it begin? _____ How did it begin? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
   Has it become worse recently? ( )Yes ( )No ( )Same ( )Better ( )Gradually Worse
4. How frequent is the condition? ( )Constant ( )Daily ( )Intermittent ( )Night Only
   How long does it last? ( )All Day ( )Few Hours ( )Minutes ( )Other _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   ( )Yes ( )No If yes, please describe _____
6. Describe the pain: ( )Sharp ( )Dull ( )Numbness ( )Tingling ( )Aching ( )Burning ( )Stabbing ( )Other
7. Is there anything you can do to relieve the problem? ( )Yes ( )No If yes, please describe _____
   _____ If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? ( )Standing ( )Sitting ( )Lying ( )Bending ( )Walking ( )Twisting
9. Have you had any broken bones? ( )Yes ( )No If yes, please list and give approximate dates:
   _____
10. List any major accidents you have had other than those that might be mentioned above: _____
    _____
11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ( )Yes ( )No If yes, please explain. _____
12. **WOMEN: Are you pregnant or is there any possibility you may be? ( )Yes ( )No ( )Uncertain**
13. What (if any) treatment have you already received for your condition? ( )Medication ( )Surgery
    ( )Physical Therapy ( )Chiropractic Services

    Name of other doctor (if any) who has treated you for this condition:_____



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

Please rate your level of pain with 1 being mild and 10 being severe: 1 2 3 4 5 6 7 8 9 10 (circle one)

For Office Use Only

Remarks:_____

_____

_____

Doctor's Signature _____ **Date** _____