Confidential Patient Case History

Name (*First Middle Last*) ______________________________ SSN______________________ Date __________

Address____ City/State/Zip_______________________________

Birth Date ____/____/____ Age_____ Spouse's Name_______________ Number of Children_____

Home Phone_____________________ Cell Phone___________________ Cell Phone Carrier ____________

Email__________________________________ Preference for Reminder Appointments: *Email* *Text Message*

Occupation___________________ Referred by__________________ Preferred Contact Number: *Home* *Cell*

Preferred Language: ______________ Race: ________________ Ethnicity: ________________

Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

General
__Allergies
__Dizziness
__Fainting
__Fatigue
__Fever
__Headache
__Loss of Sleep
__Nervousness/depression
__Numbness

Cardio-Vascular
__Heart Disease
__High blood pressure
__Low blood pressure
__Pain over heart
__Poor Circulation

Eyes, Ears, Nose & Throat
__Asthma
__Colds
__Earache
__Ear noises
__Eye pain
__Failing vision
__Nosebleeds
__Sore throat
__Sinus infection

Muscle & Joint
__Arthritis
__Foot Trouble
__Low back pain
__Neck pain or stiffness
__Spinal Curvature

Pain or numbness
__Shoulders
__Arms
__Elbows
__Hands
__Hips
__Legs
__Knees
__Feet
__Tailbone
__Sciatica

Gastro-Intestinal
__Constipation
__Diarrhea
__Difficult Digestion
__Gall Bladder trouble
__Hemorrhoids
__Nausea
__Pain over stomach
__Vomiting
__Poor appetite

Respiratory
__Chest pain
__Chronic cough
__Difficult breathing
__Spitting up blood
__Spitting up phlegm
__Wheezing

Genito-Urinary
__Bed Wetting
__Blood in urine
__Frequent Urination
__Inability to control kidneys
__Kidney infection or stones
__Painful urination
__Prostate trouble

For Women Only
__Cramps or backache
__Hot flashes
__Irregular cycle
__Menopausal symptoms
__Painful menstruation
Are you pregnant? *Yes* *No*

Check the following conditions you have had

__Alcoholism
__Appendicitis
__Arteriosclerosis
__Arthritis
__Cancer
__Cold sores
__Diabetes
__Eczema
__Emphysema
__Epilepsy
__Influenza
__Measles
__Miscarriage
__Multiple Sclerosis
__Mumps
__Pleurisy
__Pneumonia
__Polio
__Rheumatic fever
__Scarlet fever
__Stroke
__Tuberculosis
__Ulcers
__STD
__Whooping cough

Habits: Heavy/Moderate/Light/Never/Former

Alcohol __________ Coffee__________ Tobacco__________ Drugs__________ Exercise__________

IN CASE OF EMERGENCY: Name/Relation___________________________ **Phone**___________________________

Please complete back page.

Please Print and Complete the Following

Have you had previous chiropractic care? *Yes* *No* If yes, date of last treatment____________________________

What is your major complaint?____

Other complaints____

How long have you had this condition?______________ Have you had this or similar conditions in the past? __________

What activities aggravate your condition?____

Circle any that apply: Is this condition getting progressively worse? *Yes* *No* *Constant* *Comes and goes*

Is this condition interfering with your *Work* *Sleep* *Daily routine* Other ________________________________

How long has it been since you really felt good? ____

____

No Symptoms____Extreme Symptoms

Please place and "X" on the line above to indicate level of problem.

List previous diagnoses and treatment you have received for present condition__________________________________

____

What do you believe is wrong with you? ____

List surgical operations and years? ____

Are you currently taking any medications? *Yes* *No* If yes, What? ____

Do you have any medication allergies? *Yes* *No* If yes, What? ____

Do you wear any of the following: *Heel Lifts* *Sole Lifts* *Inner Soles* *Arch Supports*

Have you been in an auto accident: *Past Year* *Past Five Years* *Over Five Years* *Never*

Have you ever had any mental or emotional disorders? *Yes* *No* When?__________________________________

Family Health Information (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

Name	Relation	Past and Present Health Problems

Have you ever been knocked unconscious? *Yes* *No* Have you ever fractured a bone? *Yes* *No*

Do you take vitamin or mineral supplements? *Yes* *No* If yes, What? ____

Name of family physician ________________________________ City __________________ Phone ________________

I have been given a copy of the Patient Health Information Privacy Notice.

Patient/ Guardian Signature ____________________________________ **Date** _______________________________

Sunbury Chiropractic Center
Financial Policy

At Sunbury Chiropractic Center, our motto is “Relief First, Wellness Always.” Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans. Most of our patients have health or accident insurance that falls under one of the plans discussed in our Financial Policy brochure. Regardless of your coverage, we will suggest the chiropractic care most appropriate for your condition.

Please initial the following if applicable:

______I have received and read my copy of Sunbury Chiropractic’s Financial Policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Sunbury Chiropractic Center and my insurance company. I request that Sunbury Chiropractic Center prepare the customary forms at no charge so that I can utilize my insurance benefits. I understand that I am financially responsible for any service that my insurance company may deny as not medically necessary or any other non-covered charges.

______I authorize SCC to release any medical information to complete any customary reports and forms to assist in collection from my insurance company. I authorize payment of medical benefits to be payable to Sunbury Chiropractic Center.

If you are not the primary policy holder:

______I give permission to Sunbury Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

Or:

______I do not give permission to Sunbury Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

SCC has permission to discuss my care and insurance with the following:

Name: _____________________ Relationship: _________________ Phone: ____________

Patient Signature: ___________________________________
Patient Parent or Legal Guardian________________________
Date: ____

Sunbury Chiropractic Center
X-Ray Consent

I understand that my doctor may submit my x-rays to Professional Imaging Consultants, Inc. for radiological evaluation and analysis by a Radiologist. I understand that any fee associated with this analysis will be paid for by Sunbury Chiropractic Center as a courtesy.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Professional Imaging Consultants, Inc.
P.O. Box 36952
Canton, OH 44735

____
Patient's Signature

____
Today's Date

Consent for Treatment of Minor Child

I give permission to Sunbury Chiropractic Center to administer chiropractic care as deemed

necessary to my child ______________________________.

(Name of Child)

Patient Parent or Legal Guardian Signature: ____________________________

Witnessed: ____________________________

Sunbury Chiropractic Center
123 State Route 3
Sunbury, Ohio 43074

Date ___________

Patient Demographic Information

Name: *First*___________________________ *Last*__________________________________ *M.I.* _____

Nickname: ___________________________ Allergies: ____________________________________

SSN#: __________________________ Height: _______________________

Birthdate: _______________________ Weight: _______________________

Current Address: ____

City: _____________________________________ State: ____________ Zip: __________________

Home #: _______________________ Cell #: ________________________ Carrier: ______________

Email address: ____

Preferred contact number: _____________________________________

Preference for reminder appointments (please circle):

Phone call   Email   Text

Marital Status (please circle):

Married (Spouse Name ______________)   Divorced   Widowed   Single

Employment Status (please circle):

Full-time   Part-time   None   Student   Retired

Emergency Contact:

Name: ___________________________________

Phone #: _________________________________

Relationship: ______________________________

Payment Preference:

___Copay

___Deductible

___Payment Plan

___Time Of Service/ Discounted Rate

___Pay by Statement

-OVER-

Patient Demographic Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Preferred Language?

___ English

___ Spanish

___ Other ______________________

Race?

___ I do not wish to provide this information

___ White

___ Black or African American

___ American Indian or Alaska Native

___ Asian

___ Native Hawaiian or Other Pacific Islander

___ Other _________________________

Ethnicity?

___ I do not wish to provide this information

___ Hispanic or Latino

___ Non-Hispanic or Non-Latino

___ Other___________________________

Smoking Status?

___ Current every day smoker

___ Current some day smoker

___ Former smoker

___ Never smoker

Do you have any medication allergies?

___ No known medication allergies

___ Yes. What? ____

Are you currently taking any medications?

___ Not currently prescribed to any medications

___ Yes…

What? ____ _________ mg

What? ____ _________ mg

What? ____ _________ mg

Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074

PATIENT HEALTH INFORMATION CONSENT FORM

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 HIPPA 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 us 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 requite 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.
8. As a way of showing our appreciation, if you refer a patient to our office, your name may be added to our referral board which is located in the patient reception area. You agree to allow this to be done or will notify us upon the referral.
9. I understand that upon entering this facility, my name will be signed on a sign-in sheet that will remain in the reception area of the office. I also realize that any person entering this office may rad my name on the sign-in sheet as a patient.

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

________________________________ _________________
Name Date