File#:_____

PATIENT INFORMATION

Circle One: Mr. Mrs. Ms. Miss Dr. Gender: **M F**

Full Name: _____ Suffix: _____ Nickname: _____

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

Birth Date: _____ Age: _____ Marital Status: **S M W D Sep** # of Children: _____

Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How did you hear about our office? _____

Employer Information:

Employer: _____ Brief Description of Occupation: _____

Work Phone: _____ Ext: _____ *Circle One*: **Full Time / Part Time**

School (if student): _____

Insurance Information:

Primary Insurance Company: _____

Insured's Name: _____ Birth Date: _____

Insured's Employer: _____

Secondary Insurance Company: _____

Insured's Name: _____ Birth Date: _____

Insured's Employer: _____

Briefly describe the major complaint that brings you to our office: _____

_____

Is your condition due to an accident? **Y or N** Date of Accident: _____

Is your condition work-related? **Y or N**

Method of Payment: (Circle one)

Cash Check Credit Card Access Card Medicare Work Comp. Auto Ins. BC/BS Other Insurance

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient / Parent or Guardian Signature: _____ Date: _____

Shaffer Chiropractic
62 East Church St. Lock Haven, PA 17745
(570) 748 - 9486

File#:_____

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. An understanding of your complete health history will help us to determine the appropriate care.

HEIGHT: _____ WEIGHT: _____

Have you ever had Chiropractic care before? **YES** or **NO**

If yes, for what problem? _____

Were the results satisfactory? **YES** or **NO** What Chiropractor(s) did you see? _____

Who is your medical doctor? _____

Review of Systems

Do you have any of the following? (If yes, please explain)

CONDITION	NO	YES	EXPLAIN
Sinus Problems			
Chest or lung (breathing) Problems			
Heart or Blood Vessel Problems			
Digestive Problems			
Genital Problems (Prostate/Testicular/Vaginal)			
Urinary Problems (Kidney or Bladder)			
Nervous System Diseases or Mental Health Problems			
Gland or Hormone Problems			
Allergy or Immunity Problems			
Muscle, Tendon, or Ligament Problems			
Bone or Joint Diseases (examples: Osteoporosis, Arthritis)			

FEMALES:

CONDITION	NO	YES	EXPLAIN
Menstrual Problems			
Have you ever taken birth control pills?			For How Long?
Is there any chance that you are currently pregnant?			
Breast Problems			

Past History

1) List any diseases that you have had in the past, including childhood diseases: _____

_____

2) Have you ever been diagnosed with any condition, such as diabetes, cancer, high blood pressure, AIDS, etc? If so, please list: _____

3) Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, or broken bones? **YES** or **NO**

If yes, please explain: _____

4) List any surgeries you have had:

_____ Date: _____

_____ Date: _____

_____ Date: _____

File#:_____

5) Have you ever been hospitalized for any reason other than surgery? **YES** or **NO**

If yes, please explain: _____

6) Please list all **medications** (prescription and non-prescription) you are currently taking or take on an occasional basis:

_____

Social History

1) How many hours do you sleep each night? _____ Do you sleep continuously through the night? **YES** or **NO**

2) Do you exercise on a regular basis? **YES** or **NO** What type of exercise? _____

3) Describe your diet *(Circle one)*: Balanced Fair Poor Excessive Restricted

4) Do you smoke? **YES** or **NO** Amount per day? _____ How long have you smoked? _____

5) Do you use: *(Circle all that apply)*

Caffeine Tobacco Alcohol Recreational Drugs

Additional Questions

Please answer the following questions. If the answer is yes, please explain.

QUESTION	NO	YES	EXPLAIN
Do you have problems with recurring headaches?			
Are you losing weight without trying?			
Does your pain wake you up at night?			
Have you had a change in bowel or bladder habits?			
Have you recently had any unusual bleeding or discharge?			

1) Please add any additional information about your health history that may not have been included above:

_____

Have you ever been diagnosed with or told you have any of the following?

CONDITION	NO	YES	CONDITION	NO	YES
Stroke			Fractured/broken vertebra		
Herniated Disc			Bleeding disorder		
Osteoporosis			High blood pressure		
Hardening of the Arteries			Cancer		
TIA (Mini stroke)			AIDS		
Kidney Disease			Prostate Disease		

Do you have any surgical/medical implanted devices? **YES** or **NO** If Yes, please list: _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	