Patient Information

Today's Date_____ Acct#_____

Name_____ Social Sec. Number_____

Date of Birth _____Age _____Gender M F Marital Status S M W D # Children_____

Address_____City_____State_____Zip_____

Email_____ Home Phone _____Cell Phone_____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relationship_____Phone#_____

How did you hear about us?_____

Have you ever had chiropractic care? Y N How long has it been?_____

The purpose or reason for this appointment_____

What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic None

Do you drink alcoholic beverages? Y N How often?_____ Do you smoke? Y N How much?_____

Do you exercise? Y N How often?_____Type?_____

Do you have any allergies? (Specify)_____Date of last physical exam_____

Spinal X-Ray _____Spinal Exam_____ Chest X-ray_____ MRI, CT Scan Bone Scan_____

When was the last time you were involved in an accident of any kind? (Specify)_____

Are you pregnant? Y N First day of last menstrual cycle?_____ # of Pregnancies? _____ Miscarriages?_____

Personal Health History- Please check the box next to each condition you have now or have had in the past

- ○ Dizziness/ Fainting
- ○ Insomnia
- ○ Low Resistance
- ○ Tension
- ○ Confusion
- ○ Fatigue
- ○ Ulcers
- ○ Eye/Vision Problems
- ○ Ear/Hearing problems
- ○ Difficulty Breathing
- ○ Heart Problems
- ○ Loss of Bladder Control
- ○ Constipation
- ○ Diarrhea
- ○ Digestion Problems
- ○ Nausea
- ○ Female Problems
- ○ Prostate Problems
- ○ Hands/ Feet Cold
- ○ Hand tremors
- ○ Loss of Memory
- ○ Nervousness
- ○ Sweaty palms
- ○ Speech Difficulty
- ○ Anxiety
- ○ Irritability
- ○ Broken or Fractured Bones
- ○ Circulatory Problems
- ○ Rheumatoid Arthritis
- ○ Seizures/Convulsions
- ○ A Congenital Disease
- ○ Excessive Bleeding
- ○ High/Low Blood Pressure
- ○ Diabetes
- ○ Osteoporosis
- ○ Epilepsy
- ○ Pacemaker
- ○ Strokes
- ○ Cancer
- ○ Ruptures
- ○ Coughing Blood
- ○ Eating Disorder
- ○ Alcoholism
- ○ Drug Addiction
- ○ HIV Positive
- ○ Gall Bladder
- ○ Head Problems
- ○ Depression
- ○ Tumors
- ○ Mumps, Chicken Pox, Measles

Please identify all medications/ vitamins you have taken or are currently taking and facilities/providers you have seen or are currently seeing, if any, for your presenting problem(s)

Medication List

Medications	Vitamins/Herbs

Problem List

List any injuries: Falls, head Injuries, broken Bones, Dislocations, Surgeries, etc.

Today's Date_____ Name_____ Acct#_____

Patient History

What is your main complaint?_____

On the scale below, please circle the **Severity** of your **Main Complaint** (At its worst)

None Slight Mild Moderate Severe

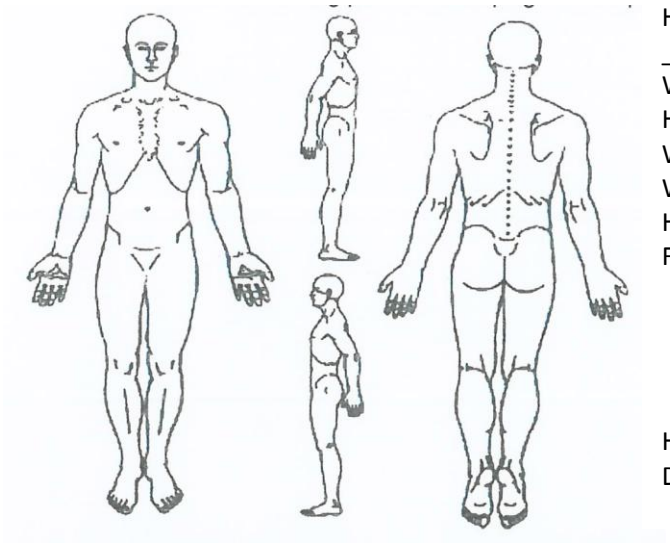
1 2 3 4 5 6 7 8 9 10

On the scale below, please circle the **Percentage of Time** you experience your **Main Complaint**

Occasional Intermittent Frequent Constant

0 10 20 30 40 50 60 70 80 90 100

On the Diagram below, please show **Where** you are experiencing **all** of your present complaints using the following letters: **A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** Throbbing pain **N:** numbing pain **T:** tingling



How **long** have you been experiencing your **main complaint**?

_____

When do you notice it most? AM PM

How long does it last? _____Min HRS

What makes it feel better?_____

What makes it feels worse?_____

Have you ever had this problem in the past? Y N

For this problem I have

- Been hospitalized
- Been treated by another chiropractor
- Been treated by another specialty provider
- Never received care

Have you lost time from work because of it? Y N

Dates? _____to_____

- Personal Care
- Lifting
- Reading
- Concentrating
- Work
- Driving
- Sleeping
- Recreation
- Walking
- Sitting
- Standing
- Social Life

Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Douglas D. Opie, DC and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Opie Chiropractic. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

By signing below, I have read, or have read to me, the above consent to evaluation and treatment statement, and that I certify that my medical information above is corrected to the best of my knowledge.

☐ I acknowledge that I have received **Opie Chiropractic's** Notice of Privacy Practices for protected health information.

Patients or Guardian's Signature_____Date_____

If minors, Parent/Guardian Signature_____Date_____

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent

For Use of Health Information

Name _____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this_____ day of _____, 20 ___

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (Circle one)

THIRD PARTY INFORMATION SHEET: NAME:_____ DATE:_____

As a courtesy to you OPIE CHIROPRACTIC'S BILLING OFFICE will file claims on your behalf at no additional charge and send to your insurance company, please fill out the information below. Please make sure that our staff has a copy of your insurance card. **You may also pay the Time of Service Fee (a reduced amount) and submit the bill to your insurance carrier for reimbursement yourself. PLEASE REFFER TO THE FINANCIAL POLICY GIVEN YOU AND READ THE PARAGRAPH THAT BEST FITS YOUR PLAN. Please understand that your insurance company states the "the Information" that they quote "is NOT a Guarantee of Payment" Therefore, you are ultimately responsible for your bill.** We will do all we can to get proper reimbursement but please be aware that the agreement you have with your insurance company is an agreement between you and them, not us.

Insurance Company_____ Phone # _____ Name of Insured_____ Relationship to Patient_____ ID number_____ Group Number_____ Do you have Secondary Insurance? Y N _____	**Do NOT fill out. For Office use only** Deductible? Y N Total?_____ Met?_____ Copay? _____ Co-Ins? _____Visit Limit?_____ Authorization Needed?_____ Patient's/Guardian's Signature _____ Date_____ Witness_____
AUTO/PERSONAL INJURY/WORKER'S COMPENSATION **What Type of Accident?** AUTO WORK OTHER_____ IF WORK, EMPLOYER?_____ WHO DID YOU REPORT TO?_____ Phone #_____ Company Insurance Carrier_____ Contact_____Phone#_____ Claim#_____ **Attorney?**_____ **Phone**?_____	MED PAY (YOUR OWN AUTO INSURANCE) Company_____ Phone #_____ Contact_____ Claim #_____ LIABILITY (SOMEONE ELSE'S INSURANCE, AT-FAULT) Company_____ Phone #_____ Contact_____ Claim #_____

IF YOU ARE ASKING OUR OFFICE TO WAIT FOR PAYMENT FOR YOUR CARE FROM A PARTY OTHER THAN YOURSELF, WE REQUIRE THAT A CREDIT CARD BE LEFT ON FILE UNTIL ALL INFORMATION IS COMPLETE AND VERIFIED.

For Work Comp and Personal Injury cases, insurance and claim information must be received within 3 business days or the card will be charged for the full amount of care.

NAME ON CARD_____BEST CONTACT#_____

MAILING ADRESS_____ZIP_____ TYPE OF CARD VISA M/C DISCOVER

CARD #_____EXP DATE_____ CVV_____