CONFIDENTIAL PATIENT HEALTH Patient: _____ Date: _____

Dr. Mr. Ms. Mrs. First:_____ Mid Initial: ____ Last:_____

Birth date: _____ Age: _____ Sex: Female/Male SSN: _____

Email Address: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Work phone: _____

Cell Phone: _____ Fax #: _____

Single Married Divorced Separated Widowed Spouse's Name: _____

Children (names & ages): _____

Emergency Contact Name: _____ Phone #: _____

Insurance Information

Who is responsible for your bill? YOU (circle all that apply) Myself only Spouse

Worker's Comp Auto Insurance Medicare Health Insurance: _____

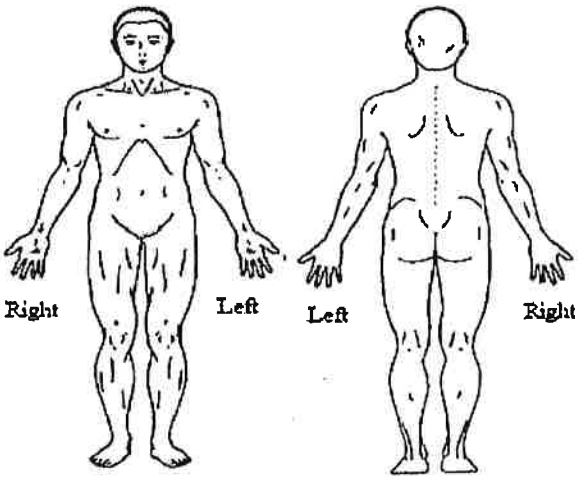
Other: _____

Personal Health Insurance Carrier: _____ Member/ID card #:_____

Policy Holder's Name:_____ Group#: _____

Policy Holders Date of Birth: _____ Primary Care Physician: _____

PLEASE LABEL THE DIAGRAM AREA OF SYMPTOM:
Mark on the figure below area of pain/numbness/burning
Use below to indicate TYPE & LOCATION
A=ache B=burning N=numbness P=pins & needles S=stabbing



Unwanted Condition/Pain (why are you here today?)

_____

I currently have: Pain/ Stiffness /Numbness/ Weakness
Condition/Pain STARTED on what date? _____
Has it ever occurred before? Yes/ No When?_____
Is this condition: **Auto Related Job Related Home injury**
Slip or fall Lifiting Slept wrong unknown causes other
EXPLAIN In your own words how the injury/pain/condition happened:

_____

_____

_____

If caused by an accident: Date:_____Time:_____

List any other condition/pain related or unrelated to one of the listed above that you are experiencing:

_____

_____

Please rate your overall pain/unwanted condition/discomfort/stiffness on a scale of 0 to 10:
0 (none) 1 2 3 4 5 6 7 8 9 10 (I should be in the ER right now)

Name: _____ Date: _____

PRIOR TEST	DATE	AREA	LOCATION/ FACILITY
X-RAY		HEAD NECK MIDBACK LOW BACK OTHER	
MRI		HEAD NECK MIDBACK LOW BACK OTHER	
CT SCAN		HEAD NECK MIDBACK LOW BACK OTHER	
NCV		HEAD NECK MIDBACK LOW BACK OTHER	
EMG		HEAD NECK MIDBACK LOW BACK OTHER	
OTHER		HEAD NECK MIDBACK LOW BACK OTHER	

MEDICATIONS: Are you taking now or have you been taking... (list)

ANY OVER THE COUNTER MEDS?	**YES NO**
HAVE YOU TAKEN ANY OF THE FOLLOWING?	Acetamiphen Tylenol Percocet Vicodin Loratab Excedrin
ANY PRESCRIPTION PAIN MEDS?	**YES NO**
ANY PRESCRIPTION MUSCLE RELAXERS?	**YES NO**
ANY OTHER PRESCRIPTION MEDS?	**YES NO**

MOTOR VEHICLE COLLISION:

Have you been involved in any motor vehicle collision? **YES NO**

Did you have permanent injury? **YES NO**

EMPLOYMENT:

Occupation/Job title: _____

Description of work duties: _____

WORK ACTIVITY POSTURES (CIRCLE ALL THAT APPLY): BENDING CLIMBING KNEELING PULLING PUSHING REACHING SITTING STANDING TWISTING WALKING

PAST CONDITIONS:

Arthritis	Depression	Hepatitis	Seizures
High Blood Pressure	Diabetes (insulin dependent)	Diabetes (non-insulin dependent)	Heart Disease
HIV	Cancer	Ear Infections	Asthma
Spina Bifida	Multiple sclerosis	Vertigo	Chicken Pox
Fibromyalgia	Crohn's Disease	Headaches	Shingles
Bed wetting	CVA (stroke)	Parkinson's	Pneumonia
Scoliosis	Other: _____		

SURGERIES:

Appendectomy	Coronary artery bypass	Cosmetic	Spinal Fusion
C-section	Gall Bladder	Cardio Cath	Hernia Repair
Pacemaker Insertion	Rotator Cuff Repair **L R**	Knee Repair **L R**	Carpal Tunnel **L R**
Hip Replacement	OTHER:		

SOCIAL HISTORY: Do you Consume Alcohol? **YES NO** Do you smoke? **YES NO**

Is there any daily or recreational activities that you had to stop or limit due to your pain/discomfort? (If YES, please list) : _____

Name:_____ Date: _____

1 = I don't do this activity
2= NO PAIN I do this activity but I have no pain while doing it
3= MILD PAIN I have mild pain while doing this activity
4= MODERATE PAIN I have moderate pain while doing this activity
5= SEVERE PAIN I have severe pain while doing this activity

DAILY ACTIVITIES:	1	2	3	4	5	How long can you do the following w/o pain?
BENDING						
CARRYING GROCERIES						
MOVEMENT SIT/STAND						
CLIMB STAIRS						
DRIVING						
WORKING ON THE COMPUTER						
HOUSEHOLD CHORES						
KNEELING						
LIFTING CHILDREN						
LIFTING						
READING						
SLEEP						
STATIC SITTING						
STATIC STANDING						
WALKING						
YARD WORK						

RECREATIONAL:	1	2	3	4	5	How long can you do the following w/o pain?
CHURCH						
COOKING						
CRAFTS						
CYCLING						
DANCING						
EXERCISE						
FISHING						
GOLF						
PILATES						
RUNNING						
TENNIS						
WALK FOR EXERCISE						
WEIGHTLIFTING						
YOGA						
OTHER:						

I acknowledge that I have received the clinics notice of privacy practices for protected heath information

Patients Signature: _____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, suck a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine or cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
PLEASE PRINT

Signature: _____ Date: _____

Witness: _____ Date: _____

David A. Wren, D.C., C.C.S.P.

Certified Chiropractic Sports Physician

Chiropractic & Sports Injury Center
Special Attention to Sports & Rehabilitation

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by the clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. We must receive your completed coverage verification prior to accepting assignment. Direct assignment will be discontinued when you have finished corrective care and a supportive health program is recommended. We will notify you of the change.
2. All deductible amounts must be paid by you in advance of the first billing. Also, you may stay current with your percentage of responsibility. This must be paid weekly.
3. The insurance carries are billed on specific 30 day cycles. It is your responsibility to supply this office with necessary forms to complete the billing.
4. If you receive payment from your insurance carrier during the period in which the clinic has accepted assignment of benefits, you are to bring the check into the office within one week of receipt and endorse it over to the clinic. Failure to do this will result in collection action.
5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company.
6. The clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay the charges and pursue reimbursement from the insurance company.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions of this program as specified above.

_____ _____

Patient's Signature Date

_____

Staff Witness

Consent for Treatment
and
Authorization to Perform X-Rays

Date_____

I have been informed by Dr. Wren that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Wren to perform such radiographic examination necessary to diagnose and to administer whatever treatment deemed necessary to treat my present problem (or illness).

Print Name:_____

Signed:_____

Witness:_____

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed:_____

David A. Wren, D.C., C.C.S.P.

Certified Chiropractic Sports Physician

Chiropractic & Sports Injury Center
Special Attention to Sports Injuries & Rehabilitation

Date_____

To:_____

From:_____

Receiving Fax:_____

General Release & Release of X-Rays

KNOW ALL MEN BY THESE PRESENTS: That I have requested the release of the x-rays and/or medical records of:

_____

Which are a part of the records of:

_____, D.C.

I hereby acknowledge receipt of these x-ray films and/or medical records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature, or character whatsoever arising from said treatment.

_____

(Witness)

_____

(Patient or legal representative)

Dated:_____

The HIPPA Final Privacy Rule requires covered entities to safeguard certain Protected Health Information (PHI) related to a person's healthcare. Information being faxed to you may include PHI after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain PHI in a safe and secure manner. You may not re-disclose without additional patient consent or as required by law. Unauthorized re-disclosed or failure to safeguard PHI could subject you to penalties described in federal (HIPPA) and state law. If you the reader of this message are not the intended recipient, please notify us immediately, or the employee or agent responsible to deliver it to the intended recipient, please notify us immediately and destroy the related message.

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