Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Marital Status: ◯Yes ◯No Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯Yes ◯No Advertisement: _____

Referred Directory: ◯Yes ◯No Referred Directory: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment: ◯Personal ◯3rd Party ◯Self Resp. for Payment: _____ Responsible Phone : _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Secondary Name: _____ Secondary Phone #: _____ Secondary ID/Policy: _____

Secondary Address: _____

Secondary City: _____ Secondary State: _____ Secondary Zip: _____

Secondary Group #: _____ Secondary Name: _____ Secondary DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Social History & Life Choices

Alcohol:	◯Daily	◯Weekly	◯Occasionally	◯Never	Caffeine Drinks	◯Daily	◯Weekly	◯Occasionally	◯Never
Diet Food Products:	◯Daily	◯Weekly	◯Occasionally	◯Never	Drugs:	◯Daily	◯Weekly	◯Occasionally	◯Never
OTC Stimulants:	◯Daily	◯Weekly	◯Occasionally	◯Never	Exercise:	◯Daily	◯Weekly	◯Occasionally	◯Never
Homemade Food:	◯Daily	◯Weekly	◯Occasionally	◯Never	Processed Food:	◯Daily	◯Weekly	◯Occasionally	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasionally	◯Never	Tobacco:	◯Daily	◯Weekly	◯Occasionally	◯Never
Water:	◯Daily	◯Weekly	◯Occasionally	◯Never					

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been adjusted by a chiropractor before? ◯Yes ◯No

If yes, what was the reason ? _____

Doctor's Name: _____ Date of last visit _____

Has any member of your family ever seen a wellness chiropractor? ◯Yes ◯No

Reason for this Visit

Describe the reason for this visit: _____

Impact on Life: _____

(Skip this section for wellness services)

◯Wellness ◯Sports ◯Auto ◯Fall ◯Home Injury ◯Job ◯Chronic Discomfort ◯Other

When did this concern begin? _____

Has this concern? ◯Gotten Worse ◯Stayed Constant ◯Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ◯Yes ◯No Briefly Explain: _____

Have you seen other doctors for this concern? ◯Yes ◯No Doctor's Name: _____

Type of Treatment: _____

Results: ◯Good ◯Bad ◯Indifferent

Women Only

Are you pregnant?	◯Yes	◯No	**Are you taking birth control?**	◯Yes	◯No	**Do you have irregular cycles?**	◯Yes ◯No
Are you nursing?	◯Yes	◯No	**Do you experience painful periods?**	◯Yes	◯No	**Do you have breast implants?**	◯Yes ◯No

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition.

☐ Relief Care: Symptomatic relief of pain or discomfort.

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Were you aware that...

Doctors of Chiropractic work with the nervous system?

◯ Yes ◯ No

The nervous system controls all bodily functions and systems?

◯ Yes ◯ No

Chiropractic is the largest natural healing profession in the world?

◯ Yes ◯ No

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

☐ I agree with this statement of authorization *

Name of the Insured : _____

Patient's / Guardian's Signature: _____

Date: _____

Further, I assign to the Clinic any and all rights, claims of action I may have against any insurance company, to include my own, arising from the recovery of benefits for payment of services provided to me by the Clinic. In event that payment by insurance company is refused upon demand by either myself or the Clinic, I authorize the Clinic to compromise, settle or otherwise resolve any claim or cause of action which I may have against the insurance company. I understand and agree that I remain personally responsible for the total due and owing for services provided to me by the Clinic, to include any such amount as may remain due and owing following such compromise, settlement or resolution of insurance benefits. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

I understand and agree that payment for services provided to me by the Clinic are due and owing immediately upon the rendering of such services. I understand and agree that if payment for such services is not made when due and owing, the Clinic may file a lien for reasonable charges for services against any and all causes of action, suits claims, counterclaims or demands accruing to me or my legal representative, on account of the injuries given rise to such causes of action and for which treatment was rendered. I understand and agree that the Clinic may demand that payments for Clinic services provided to me be kept current, and that any amount due and owing for more than thirty (30) days shall accrue interest at the rate of three percent (3.0%) per month until paid in full.

NOTICE OF PRIVACY PRACTICE

I have read the **HIPAA Notice of Privacy Practices** and I understand the circumstances in which my protected health information may be used by this clinic and its agents.

This document authorizes Storey Chiropractic Clinic, P.C. to release medical information and reports as deemed necessary by the physician to my insurance company and/or attorney.

I certify that I'm the patient or legal guardian.

_____ **Date**_____

Signature of Patient

_____Initial of office witness