PATIENT INFORMATION – Please print

## GENERAL INFORMATION

Patient's last name _____ First _____
Address_____
City_____State_____Zip_____
Home phone _____Work phone_____Cell_____
Married____Single____Divorced_____Widowed _____ Date of birth_____
Sex: M__F__ Employed: Ft__Pt__Retired__ Social Security # _____
Spouse's name_____# Children_____
Patient's Employer_____
Patient's Occupation_____Employer's phone_____

E-Mail Address:_____

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Referred by:_____

## INSURANCE INFORMATION

Primary Insurance _____ID#_____
Policy holder's name_____ Group #_____

Secondary Insurance_____ID#_____
Policy holder's name_____ Group#_____

Auto Insurance/Worker's Comp
Insurance Company_____Claim #_____
Policy#_____Adjuster's Name_____
Address_____City_____State_____Zip_____

Attorney's Name_____ Phone_____
Address_____City_____State_____Zip_____

### RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's signature_____ Date_____

Disclaimer: The physicians operating in Fleming Island Chiropractic, Inc. are independent contractors. Fleming Island Chiropractic., Inc. shall not be responsible for the acts and omissions of any of the physicians operating at the facility. Similarly, no physician operating in Fleming Island Chiropractic, Inc. shall be responsible for the acts and omissions of another.

# PATIENT HISTORY

Please fill in the appropriate spaces. (All information given is confidential)

Name:_____ Date:_____
Major Complaint:_____
How long have you had this condition?_____
Date of onset_____
Have you lost work days?_____yes _____no If yes, how many?_____
Have you had this similar condition before? ___yes___no If yes, when_____
Was the injury accident related? ___auto ___work comp. If yes, when_____
When was your last auto accident?_____
Previous Chiropractic Care ___yes ___no Chiropractor's name_____
What was the reason for your initial visit?_____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine _____
Did you follow it?_____ If not, why? _____
Why are you changing Chiropractors? _____
What surgeries have you had? _____
List drugs you now take (prescription and non-prescription) _____
Name other doctors you have seen for this condition_____
What are your health goals? _____
How do you expect to achieve these goals? _____

Please check if you have had any of these symptoms in the past 12 months: Not including symptoms from recent auto Accident.

___Fractured bones
___Auto accidents
__0-1 years ago
__1-5 years ago
__5 yrs or more
___Other accidents, falls
___Arthritis
___Diabetes
___Convulsions, epilepsy
___Skin problems
___Cancer
___Frequent colds
___Depressed
___Irritable
___Anemia
___Allergy, sinus
___Under stress
___Eating disorders
___Trouble sleeping
___Trouble concentrating
___Learning disability
___Mood changes

___Neck pain or stiffness __R--L
___ Numbness, tingling, pain in arms, hands fingers R__L__
___Jaw pain or click (TMJ) R__L__
___Difficulty in excessive standing sitting, riding, bending, lifting, twisting
___Shoulder pain R__L__
___Dizziness
___Ringing in ears R__L__
___Hearing loss
___Blurred or double vision
___Upper back pain, stiffness
___Mid back pain, stiffness
___Lower back pain, stiffness
___Pain with cough, sneeze
___Hip pain R__L__
___Headaches

__Numbness, tingling, pain in buttocks,legs,feet,toes __R__L
__Foot trouble __R__L
__Chest pain
__Heart problems
__Stroke
__High/low blood pressure
__Varicose veins
__Liver trouble
__Gall bladder trouble
__Digestive problems
__Ulcers
__Hemorrhoids
__Prostate problems
__Impotence
__Kidney trouble
__Menstrual problems, PMS
__Pregnant (now)
__Bedwetting
__Ear infections
__AIDS, HIV

# TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application for forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD
I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE
This is to certify that to be best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
Signature Date

## POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee for treatment x-rays is for analysis only. The film itself is the **property of this office** and can be checked out if necessary.

3. Method of payment you plan to use to take care of today's charges?

   Cash Check Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Fleming Island Family Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Fleming Island Family Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount, I authorize Fleming Island Family Chiropractic to obtain a credit report if deemed necessary.

Patient signature_____ Date _____

Guardian Signature Authorizing Care_____

In case of emergency, notify_____

Relationship _____ Phone _____

Address _____

_____

# ACKNOWLEDGE OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to read a copy of the Notice of Privacy Practices and that I read or declined reading them. I understand that this form will be placed in my patient file and maintained for six years.

_____ _____

Patient Name (Print) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

# INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by _____. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personal, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me, is not expected to be able to anticipated and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at the time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Patient's Name (Please Print)

_____
Witness's Name

_____
Patient's Signature

_____
Witness's Signature

_____
Date

_____
Date

_____
Patient's Representative (If patient is a minor or if physically or mentally impaired)

_____
Witness's Signature

_____
Representative's relationship to the patient

_____
Translated By

_____
Doctor's Name

_____
Doctor's Signature

# Assignment of Benefits and Directions to Pay

I,_____ hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay FLEMING ISLAND FAMILY CHIROPRACTIC for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance, and may be revoked with the express written consent of FLEMING ISLAND FAMILY CHIROPRACTIC. This assignment of insurances benefits pertains to any and all professional services, provided by FLEMING ISLAND FAMILY CHIROPRACTIC in relation to my health insurance and/or motor vehicle accident of _____.

This assignment of insurance benefits is provided so that FLEMING ISLAND FAMILY CHIROPRACTIC, may attempt to collect any unpaid and over-due insurance benefits directly from the insurance carrier. This includes the assignment of any cause of action that may accrue against any such in insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional, medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to FLEMING ISLAND FAMILY CHIROPRACTIC needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout to check ledger reflection insurance benefits that have been paid out on my behalf.

A copy of this agreement will be as valid as original.
I have read and I do understand this assignment thoroughly.

_____ Date_____
Patient Signature

_____
Signature of Legal Guardian (When Patient is a Minor Child)

**ACKNOWLEDGE OF RECEIPT**
**OF**
**MASSAGE THERAPY GUIDELINES**

I, _____ acknowledge that I was provided the opportunity to read a copy of the Massage Guidelines and notice of cancelation fee. I understand that this form will be placed in my patient file and maintained for six years.

Please provide 24-hour notice to avoid $25 cancelation fee

Please arrive 5 minutes prior to scheduled massage time

Late arrival may be deducted from your massage time that day and full payment will still be collected.

Credit Card: _____
Cvv: _____ Expiration date: _____Zip code:_____

_____ Date_____
Patient Signature

**ACKNOWLEDGE OF RECEIPT**
**OF**
**CELL PHONE GUIDELINES**

I, _____ acknowledge that I was provided the Cell Phone Guidelines. I understand that this form will be placed in my patient file and maintained for six years.

**Phones are to be put on silent while in our office to prevent disturbing other patients. If you need to take a call, we ask you do so outside.**

**The Therapy Room is a "NO CELL PHONE ZONE"**
**Cell Phones are to be put away while in therapy**
**This time is important to rest and reset. Talking, sounds, beeps, bright lights, and chimes are a distraction for you and others.**

_____ Date_____
Patient Signature