DynamicCare chiropractic

Today's Date_____

Patient Information

Name: (First, middle, last)_____Date of Birth:_____
Mailing address:_____(City, State, Zip)_____
Social Security Number:_____ Sex: M F Marital Status: Single Married Widowed Divorced
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Preferred Name:_____ Maiden Name:_____Email:_____

Employment Information

Employment status: ☐ Employed ☐ Part-time student ☐ Full-time student ☐ Other:_____
Employer:_____ Occupation:_____
Address:_____ (City, State, Zip)_____

Responsible Party Information (Legal guardian if patient under 18 years of age)

Name:_____ Date of Birth:_____
Address:_____ (City, State, Zip)_____
Social Security Number:_____ Phone:_____Relationship to patient:_____
Employer:_____ Occupation:_____ Employer phone:_____

Spouse Information

Name: (First, middle, last)_____Date of Birth:_____
Mailing address:_____(City, State, Zip)_____
Social Security Number:_____ Employer:_____Employer phone:_____

Emergency Contact Information

Name:_____ Phone:_____Relationship to patient:_____
Address:_____ (City, State, Zip)_____

Is your injury related to the following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of accident) _____
If Employment related, has employer been notified: ☐ Yes ☐ No
Employer contact name:_____ Employer contact Phone and extension:_____

Primary Care Physician Information

Primary Care Physician Name:_____ Phone:_____

How were your referred to our Office:

☐ By a doctor ☐ By an Attorney ☐ By another patient Other:_____Print name of your source:_____

DynamicCare chiropractic

History of present complaint

Chief complaint:_____ Purpose of appointment:_____
Date symptoms appeared/date of accident:_____ Days lost from work:_____
What does this prevent you from doing or enjoying:_____
Have you ever had the same or similar condition: Yes No If this is a recurrence, when was the first time you noticed this problem:_____
How did it originally occur:_____
Has it become worse recently: ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually worse
If yes, how and when?_____
How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night only
How long does it last: ☐ All Day ☐ Few Hours ☐ Minutes
Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Other:_____
Is there anything you can do to relieve the problem? Yes No
What have you tried?_____
What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Other
Are there any other conditions or symptoms that may be related to your complaint?_____
Date of last physical exam: _____ Are there other health problems or problems you would like the doctor to evaluate?_____
WOMEN ONLY: Are you pregnant or is there any possibility you might be pregnant: Yes No Uncertain
Last mammogram was:_____

Past Medical History

☐ Broken or fractured Bones	☐ Osteoarthritis	☐ Eating Disorder
☐ Circulatory Problems	☐ Epilepsy	☐ Alcoholism
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive
☐ A Congenital Disease	☐ Cancer	☐ Gall Bladder
☐ Excessive Bleeding	☐ Ruptures	☐ Depression
☐ High/Low Blood Pressure	☐ Coughing Blood	☐ Ulcers

Do you have a history of stroke or hypertension? Yes No If yes, when?_____
Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Yes No If yes, please describe:
_____
Women, please include information about childbirth (include dates)_____
Have you been treated for any health condition by a physician in the last year? (if yes, explain) _____
_____
What medication or prescription drugs are you taking?_____
_____
Do you have any allergies, especially to medications?_____
Have you ever received chiropractic care?_____ When was your last visit?_____

Do you drink alcoholic beverages: ☐ Yes ☐ No If yes, how much per week?_____
Do you use any tobacco products? ☐ Yes ☐ No Do you smoke: ☐ Yes ☐ No If yes, how much_____
If no, when did you quit?_____
Do you take vitamin supplements? Please list_____
_____
Do you consume caffeine? ☐ Yes ☐ No If yes, how much per day?_____
Do you exercise? ☐Yes ☐ No If yes, how often?_____
What are your hobbies?_____
Does your present condition limit your work or hobbies?_____
What percentage of the time during the day do you spend: Lifting:_____ Sitting:_____ Bending:_____
Working at a computer:_____

Family Medical History

Father: ☐ Living ☐ Deceased Age if still living:____ Cause and date of death if deceased?_____
Mother: : ☐ Living ☐ Deceased Age if still living:____ Cause and date of death if deceased?_____
Check if applicable: ☐ As an adopted child, little is known about my birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:_____
_____
Family diseases (Check if applicable and indicate whether family member is **F**ather, **M**other, **B**rother, **S**ister):

Asthma_____	Cancer_____	Mental Illness_____
Diabetes_____	Tuberculosis_____	Heart Disease_____
Stroke_____	Lung Disease_____	Kidney Disease_____
Arthritis_____	Liver Disease_____	Other_____

Consent to treatment / Financial Responsibility and Assignment of Benefits

Authorization and release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure payment benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I voluntarily consent to receive medical and healthcare services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Dynamic Care Chiropractic all of my rights, title, and interest to medical reimbursement benefits under my insurance policy. I authorize the release and transfer of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. By my signature below, I acknowledge that I have read, understand and that I have been advised that if it becomes necessary to use outside collection/credit reporting agency to secure payment of the balance due, a 30% fee will be added to my account. I thus agree to pay all costs of collection, including attorney fees and waive my exemption under the constitution of laws of the State of Colorado.

_____
Name (please print) Signature Date

_____
Doctor's signature

DynamicCare chiropractic

Patient Health Information Consent Form

We want you to know how your Patient Health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

1. I understand and agree to allow Dynamic Care Chiropractic to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that said office will limit the release of PHI to only the minimum required by insurance companies for payment.

2. I understand that I have the right to examine and obtain a copy of my health records at any time and request corrections. I further understand that I may request to know what disclosures have been made and submit in writing any further restrictions on the use of my PHI. I understand that Dynamic Care Chiropractic is not obligated to agree to those restrictions.

3. I understand that my written consent need only be obtained one time for all subsequent care given me in this office.

4. I understand that I may provide a written request to revoke consent at any time during care and that this would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care after the request has been presented.

6. I authorize Dynamic Care Chiropractic to contact me by telephone or mail for appointment reminders, announcements, newsletters, post-cards, or to check on my condition/status. I further acknowledge and agree that this chiropractic office may also contact me to inform me about their practice and staff or any future special events.

7. I understand I have the right to file a formal complaint with Dynamic Care Chiropractic about any possible violations of these policies and procedures.

8. I understand that Dynamic Care Chiropractic reserves the right to make changes to this notice and to make new notice provisions effective for all protected health Information that it maintains. I further understand that I will be provided with a new notice at my next visit following any change.

9. I understand that if I refuse to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

_____

Name of Patient

_____

Signature (patient / legal guardian) Date