Patient Information

Date:_____

Name:_____ Birth Date: _____Age: _____ Marital: M S W D

Address:_____ City:_____ State:_____ Zip:_____

E-mail address:_____ Phone:_____

Occupation:_____ Employer:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and ages of Children:_____

_____

Name of Nearest Relative (emergency contact):_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____ Clinic Name/Location:_____

Please check any and all insurance coverage that may be applicable in this case**:**

__ Major Medical __ Worker's Compensation __Medicaid __ Medicare __Auto Accident
__ Medical Savings Account & Flex Plans __Other

Name of Primary Insurance Company:_____
Name and Birth date of Primary Cardholder: _____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of 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.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient History

Chief Complaint/Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other_____Days lost from work: _____

Have you ever had a similar condition? Yes No If yes, when and describe:_____

_____

Please list and date any major illnesses, injuries, falls, auto accidents or surgeries. Women: please include information about childbirth and if you are currently pregnant: _____

_____

Date of last physical examination: _____

Have you been treated for a health condition by a physician in the past year? Yes No

If yes, describe:_____

Medications currently taking: _____

Do you have allergies to any medications? Yes No If Yes, describe: _____

Do you have any allergies? Yes No If Yes, describe: _____

Do you have a congenital condition? Yes No If Yes, describe: _____

Please indicate if you have these conditions currently or in past history (If yes, circle N for NOW or P for PAST):

Neck Pain	N	P						
Stiff Neck	N	P	Circulation Problems	N	P			
Headaches	N	P	Hands Cold	N	P			
Frequency: _____			Feet Cold	N	P	Frequent Colds	N	P
			Numbness in Fingers	N	P	Fever	N	P
Back Pain	N	P	Numbness in Toes	N	P	Sinus Problems	N	P
Shoulder/Arm Pain	N	P						
Tension	N	P	Weakness in Extremities	N	P	Difficulty Urinating	N	P
			Muscle Spasms	N	P	Irritable Bowel Syndrome	N	P
Nervousness	N	P	Joint Pain/Swelling	N	P	Indigestion	N	P
Irritability	N	P						
Depression	N	P	Broken Bones/Fractures	N	P	Gall Bladder Problems	N	P
			Arthritis	N	P	Ulcers	N	P
Fatigue	N	P	Osteoarthritis	N	P	Menstrual Problems	N	P
Sleeping Problems	N	P	Osteoporosis	N	P			
Thyroid Problems	N	P	Rheumatoid Arthritis	N	P	Loss of Balance	N	P
Weight Loss/Gain	N	P				Loss of Taste	N	P
			Seizures/Epilepsy	N	P	Loss of Smell	N	P
Heart Disease	N	P	Excessive Bleeding	N	P	Loss of Memory	N	P
Chest Pains/Tightness	N	P	Coughing Blood	N	P			
Pacemaker	N	P	HIV Positive	N	P	Fainting	N	P
High Blood Pressure	N	P				Dizziness	N	P
Low Blood Pressure	N	P	Cancer	N	P	Buzzing/Ringing in Ears	N	P
Stroke	N	P	Drug Addiction	N	P	Eyes - Light Sensitivity	N	P
Diabetes	N	P	Alcoholism	N	P			
			Eating Disorder	N	P			

Please indicate whether you engage in the following (circle O for Often, S for Sometimes, N for Never):

Vigorous Exercise	O	S	N	Tobacco Use	O	S	N
Moderate Exercise	O	S	N	Financial Pressures	O	S	N
Caffeine	O	S	N	Family Pressures	O	S	N
Drug Use	O	S	N	Other Mental Stressors	O	S	N
Alcohol Use	O	S	N	Other (specify)			

OFFICE FINANCIAL POLICY

CASH

1. **All patients are on a cash basis until their respective insurance coverage and deductible, can be verified by our staff.**

2. **This office may make payment plan arrangements on an individual basis. Any such plan of arrangement will be discussed during your report of findings.**

INSURANCE

1. **If you have insurance we will gladly process any paperwork and insurance information needed for insurance reimbursement. Provided we have prior certification from your insurance company.**

2. **We provide the information for insurance reimbursement as a courtesy to you. You are responsible for the bill or services rendered whether or not insurance covers the care. We are not a mediator between you and your insurance company and will not enter into any dispute, as your contract is between you and your insurance company.**

3. **All services are to be paid for at the time of service or through the contract agreed upon by both parties involved.**

Thank you,

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature **Date**

Soltis Family Chiropractic

Acknowledgment of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in **Soltis Family Chiropractic's** Notice of Privacy Practices. **Soltis Family Chiropractic** is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.
Those individuals or parties that could have access to Patient Health Information at **Soltis Family Chiropractic** include but may not be limited to:
The Staff of **Soltis Family Chiropractic** this includes:
Dr. Jeff Soltis, Dr. Leah Soltis, Dr. Matt Feriancek, Kellie Schultz CA, Kristie Dustin CA, & Megan Goldman CA, Lindsay Beletti PR.

By signing below, you are acknowledging that you have reviewed a copy of Soltis Family Chiropractic's Notice of Privacy Practices.

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____
_____

Signature: _____ Date: _____

Soltis Family Chiropractic USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____
_____

Signature: _____ Date: _____

Office Use Only
□ 1
□ 4-5
□ >5

Patient #:_____

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~