ChiropracticCare of Tri-Cities

PATIENT INFORMATION

Name: _____ **Date:** _____
Last First Middle

Address: _____
City State Zip Code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Referred By:** _____

Social Security No.: _____ **Birthdate:** _____ **Age:** _____ **Sex:** ❑ Male ❑ Female

Primary Care Physician: _____ **Spouse Name:** _____

Emergency Contact Name and Phone No.: _____

Email:

RECORDS AUTHORIZATION

❑ **Yes**
❑ **No** **I authorize phone messages may be left on my answering machine.**

I authorize all medical records to be released and or discussed with: _____
(Spouse/family member, etc...)

CONSENT FOR PAYMENT AND TREATMENT

I authorize my insurance company to make payment directly to the providers of Chiropractic Care of Tri-Cities in an amount equal to their contracted fee for treatment. I authorize the office of Chiropractic Care of Tri-Cities to release any information pertinent to any insurance company, adjuster attorney to facilitate collection by signing this agreement. I authorize the providers of Chiropractic Care of Tri-Cities to examine any and all healthcare records pertaining to any injury or condition I am seen for. In the case of an auto accident or third-party accident, I assign the providers of Chiropractic Care of Tri-Cities any and all insurance benefits, settlement or judgement proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with the providers of Chiropractic Care of Tri-Cities are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees. I am aware that I am solely responsible for paying the providers of Chiropractic Care of Tri-Cities for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services.

I hereby consent to the performance of chiropractic treatment including but not limited to chiropractic adjustment, and diagnostic X-ray by Drs. Oberg, Lucas, White and Watson. I understand that no guarantee or assurance has been given about this treatment.

Patient's Signature:	**Date:**
If minor, Parent's Signature:	**Date:**

MEDICARE DISCLAIMER

To our Medicare patients; We accept assignment on all Medicare patients and chiropractic treatment is a covered service. Exams for chiropractic treatment are a non-covered service with Medicare. Routine maintenance visits are a non-covered service with Medicare. Medicare will not pay for products sold by a Chiropractor (i.e. pillows, braces etc...) Charges not covered by Medicare or your supplemental insurance may become your responsibility. I have read and understand the above.

Patient's Signature:	**Date:**

ChiropracticCare of Tri-Cities

Treatment Consent Form

Name: _____ **Date:** _____
Last **First** **Middle**

_____
Patient ID No.

Treatment Disclosure Information

Chiropractic examination and therapeutic procedures (including spinal and extremity adjustments, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries of the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs, and fractures. Serious complications are estimated to be in the range of 0.5 to 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the lower back. Additional information on side-effects, complications, and effectiveness of chiropractic adjustments are available upon request.

Treatment Agreement Statement

After examination by the Doctor my treatment recommendations will be explained. I reserve the right to refuse care at any time. By signing below, I state I have read, or have had read to me, the above. I have also had an opportunity to ask questions. All my questions have been answered to my satisfaction. I consent to treatment at this office and I have the right to revoke this consent, in writing, at any time.

HIPAA Compliance Notice

I have received a copy of the HIPAA Compliance Notice. Initial:

Treatment Consent Signatures

Patient's signature:	**Date:**
If Minor, Name of Parent/Guardian: **Parent/Guardian signature:** **Consent to treat Minor in Parent's absence: YES / NO (please circle one)**	**Date:**
Doctor's signature:	**Date:**

Personal Health Profile

Name	Date	Date of Birth	Weight	Height	Age	Marital status

Occupation	Number of children and ages	Name of Spouse

Referred by	Date problem started

Other doctors seen for this problem

Diagnosis

Describe current problem

Have you had this problem before? ❑ No ❑ Yes If yes, describe below:

Does your present complaint involve any of the following:

- ❑ Dizziness
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Fainting
- ❑ Headaches
- ❑ Poor appetite
- ❑ Shoulder/arm pain R/L
- ❑ Numbness/tingling in shoulder/arm R/L
- ❑ Pain between shoulders
- ❑ Hip pain R/L
- ❑ Thigh pain R/L
- ❑ Calf pain R/L
- ❑ Foot pain R/L
- ❑ Numbness or tingling in leg/foot R/L
- ❑ Sinus trouble
- ❑ Sore throat
- ❑ Visual disturbance
- ❑ Pain in abdomen
- ❑ Stomach nausea
- ❑ Vomiting
- ❑ Gas
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Pain across belt line

What position, movement, or activity makes this worse?

What do you do, take, or put on this that helps?

Do you have regular troubles with:

- ❑ Your present complaint
- ❑ Headaches
- ❑ Neck pain
- ❑ Sinus trouble
- ❑ Sore throat
- ❑ Canker sores
- ❑ Deafness
- ❑ Dizziness
- ❑ Earaches
- ❑ Eyes
- ❑ Lower back pain
- ❑ Shoulder pain R/L
- ❑ Between shoulder pain
- ❑ Arm pain R/L
- ❑ Hand pain R/L
- ❑ Hip pain R/L
- ❑ Leg pain R/L
- ❑ Acid stomach
- ❑ Nervous stomach
- ❑ Bladder infections
- ❑ Menstrual cramping or irregularity
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ High or low blood pressure

Have you ever had:

- ❑ Cancer
- ❑ Diabetes
- ❑ Heart trouble
- ❑ Stroke/TIA
- ❑ Kidney infections
- ❑ MS
- ❑ Ulcers
- ❑ Pneumonia

When did you last visit a:

Dentist ❑ Within 1 year ❑ When _____

Family doctor ❑ Within 1 year ❑ When _____

Eye doctor ❑ Within 1 year ❑ When _____

Chiropractor ❑ Within 1 year ❑ Who _____

Last X-rays taken (when/why): _____

List past surgeries or serious illnesses and date: _____

List past broken bones and date: _____

List past auto accidents or serious falls and date: _____

List medications you take now or in the past: _____

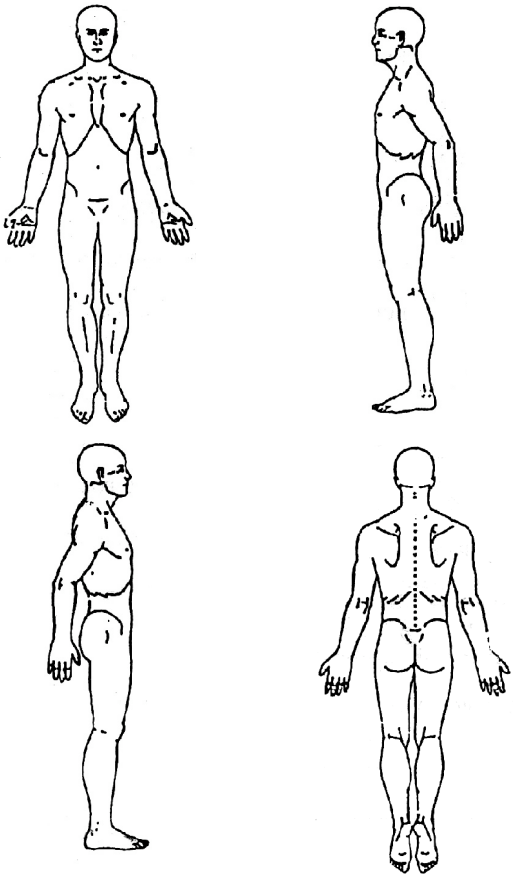
My activity is restricted: (mark on line below)

No Restrictions ——— Bed Ridden

Today my pain is: (mark on line below)

No Pain ——— Unbearable Pain

Please mark on the drawings the location of your complaint.



Are you currently pregnant: ❑ Yes ❑ No ❑ Not sure

Do you currently:

- ❑ Smoke_____, packs per day
- ❑ Use narcotics
- ❑ Consume alcohol, ❑ Frequently ❑ Infrequently
- ❑ I have the following conditions (not listed above): _____

❑ These are true answers of myself, _____
Signed

The Chiropractic Office of Drs. Oberg, Lucas, White, and Watson, 604 Williams Blvd., Richland, Washington 99354, 509-946-0631, fax 509-946-0632

ChiropracticCare of Tri-Cities

PERSONAL / FAMILY / SOCIAL HISTORY

Patient Name _____ DOB: _____

1. **Preferred Contact method:** **Phone** **Email** **Mail**

2. **Current Email Address:**_____

3. **Height:** _____ **Weight:** _____ **Blood Pressure:**_____

4. **Preferred Language:** English _____Spanish _____ Other _____

5. **Race - (please circle one):** Caucasian Hispanic or Latino African American Asian Other Indian Multi-Racial American Indian Alaskan Native Native Hawaiian or Pacific Islander

6. **Have you had any serious accidents, injuries, or illnesses? If so, please list them:**

7. **Current *Prescription* Medication:** (We will be happy to make a copy of your list!) **NONE**_____

Medication	Dosage

8. ***Medication* Allergies NONE** _____

Medication	*Severity*	*Reaction*
	Mild, Moderate, Severe	
	Mild, Moderate, Severe	

9. **Have you had any of the following:** Cancer Diabetes Heart Disease High Blood Pressure Stroke Alzheimer's Other_____

10. **Has a family member had any of the following:** Cancer Diabetes Heart Disease High Blood Pressure Stroke Alzheimer's Other_____

11. **Do you use:**

	Current, **every** day	Current, **some** day	**Former** user	**Never** used
Alcohol				
Tobacco				
Illicit Drugs				

Please let the office know if you would like a summary of your office visit today provided within a timely manner

ACCIDENT REPORT

Name: _____ **Date:** _____
Last **First** **Middle**

Insurance Information	**My (auto/workman comp.) insurance is:**	**Claim #**	
	My personal insurance is:		
	Driver's name of other vehicle, if applicable:		
	Name of their insurance company?		
Do you have an attorney that has advised you in this claim?		❑ **Yes** ❑ **No**	
Attorney's Name:	**Address:**		**Phone:**

ACCIDENT INFORMATION

Date of Accident: **Hour:** ❑ **AM** ❑ **PM**

Accident Location:

How did the accident happen?

If Auto Accident	**How many people were in the auto?**		
	Were you the:	❑ **Driver** ❑ **Passenger (Front Seat)**	❑ **Pedestrian** ❑ **Passenger (Back Seat)**
	Was your car struck from:	❑ **Behind** ❑ **Left Side**	❑ **Front** ❑ **Right Side**
	Did your car strike the other(s) involved?	❑ **Yes** ❑ **No**	❑ **Undetermined**
	Did the other car strike yours?	❑ **Yes** ❑ **No**	❑ **Undetermined**
	Were you wearing a seatbelt?	❑ **Yes** ❑ **No**	❑ **Undetermined**

INJURY INFORMATION

What happened to you at the time of impact?		
What did you feel immediately after the accident?		
When did you first notice symptoms from the accident?		
Where were you taken after the accident?		
What was done to you there?		
Did you require post-accident hospitalization?	❑ **Yes** ❑ **No**	**Where?**
List all the doctors and type of treatment since the accident.		
Have you lost any days from work?	❑ **Yes** ❑ **No**	**If yes, what kind of work and when?**
Did you return to work?	❑ **Yes** ❑ **No**	**If yes, on what date?**

Patient's Signature:	**Date:**
If Minor, Parent's Signature:	**Date:**