Patient Information

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First M Last

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex 🞎Male 🞎Female

Patient SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎Married 🞎Single 🞎Widowed 🞎Divorced 🞎Separated 🞎Minor

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? 🞎Yes 🞎No How many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Patient Welcome Form

Health Insurance

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First M Last

Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex 🞎Male 🞎Female

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient 🞎Self 🞎Spouse 🞎Child 🞎Other

* If you selected “self” please stop here and proceed to the next section.
* Please give insurance card to front desk for copying

Secondary Health Insurance

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First M Last

Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex 🞎Male 🞎Female

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient 🞎Self 🞎Spouse 🞎Child 🞎Other

Patient Condition

What is your main complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please shade the complaint area(s).**

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What started the problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate any other symptoms that you have experienced:**

🞎Dizziness 🞎Memory Loss 🞎Headaches 🞎Numb Feet/ Toes

🞎Irritability 🞎Ears Ringing 🞎Back Pain 🞎Difficulty Sleeping

🞎Fatigue 🞎Jaw Problems 🞎Chest Pain 🞎Arm/ Shoulder Pain

🞎Leg Pain 🞎Back Stiffness 🞎Blurred Vision 🞎Numb Hand/ Fingers

🞎Tension 🞎Low Back Pain 🞎Neck Stiffness 🞎Shortness of Breath

🞎Nausea 🞎Buzzing in Ear 🞎Neck Pain 🞎Upset Stomach

🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Questionnaire

Do you have a personal physician? 🞎Yes 🞎No

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? 🞎Yes 🞎No

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated by a chiropractor? 🞎Yes 🞎No

Chiropractor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last date of your last:

Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spinal X-Ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CT Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Woman:

Are you taking birth control? 🞎Yes 🞎No

Are you currently nursing? 🞎Yes 🞎No

Are you pregnant? 🞎Yes 🞎No

If yes, due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced or are you currently experiencing any of the following conditions?

Put “C” for any current conditions

**Please check all that apply** 🞎Cancer 🞎Glaucoma 🞎Leukemia 🞎Rheumatism

🞎Abnormal Bleeding 🞎Chemotherapy 🞎Gout 🞎Liver Disease/Problems 🞎Scarlet Fever

🞎Alcoholism 🞎Chicken Pox 🞎Hay Fever 🞎Low Blood Pressure 🞎Sciatica

🞎Allergies 🞎Colitis 🞎Headaches 🞎Lupus 🞎Scoliosis

🞎Alzheimer’s 🞎Congenital Heart Defect 🞎Head Injury 🞎Migraine 🞎Seizures

🞎Anemia 🞎Depression 🞎Heart Disease 🞎Mitral Valve Replacement 🞎Shingles

🞎Arthritis 🞎Difficulty Breathing 🞎Hemophilia 🞎Obesity 🞎Sickle Cell Disease

🞎Artificial Bones/ Joints 🞎Drug Abuse 🞎Hepatitis 🞎Pacemaker 🞎Sinus Problems

🞎Artificial Valves 🞎Epilepsy 🞎Herpes 🞎Persistent Cough 🞎Sleep Disorder

🞎Asthma 🞎Emphysema 🞎High Blood Pressure 🞎Psychiatric Problems 🞎Stroke

🞎Blood Clots 🞎Fainting Spells 🞎HIV/ AIDS 🞎Radiation Treatment 🞎Thyroid Problems

🞎Blood Transfusion 🞎Fatigue 🞎Kidney Problems 🞎Rheumatic Fever 🞎Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Health Information

Please list any prescriptions or over the

counter drugs you are currently taking.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any vitamins or herbs

you are currently taking.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all known allergies and any

medications you have reactions to.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization and Medical Release

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status.

I understand that the health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making my collections from the insurance company. Any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize Fox Chiropractic and Wellness Center to furnish all the information required by the insurance company concerning my injury or illness. I hereby authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. In addition, I agree to grant full indemnity to Fox Chiropractic and Wellness Center from all liability for any medical complications incurred resulting from or related to pre-existing conditions medically diagnosed or otherwise not disclosed by me.

Patient or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent

Chiropractic Care with Dr. Brandon D. Fox, D.C.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. Please feel free to discuss directly with Dr. Fox any questions or concerns you may have.

**Disc Herniation**: Disc herniations are frequently and successfully treated by chiropractors. Occasionally, chiropractic treatment may aggravate the problem, and rarely surgical intervention may become necessary if the chiropractic care is not successful. Very rarely, chiropractic adjustments may also cause a disc problem if the disc is already damaged or in a weakened condition. These problems occur so rarely that there is no available statistical information to quantify their probability.

**Soft Tissue Injury**: Soft tissues primarily refer to muscles, tendons, and ligaments. Rarely, a chiropractic adjustment, traction, massage, etc. may overstretch or tear some muscle, tendon, or ligament fibers. The result is a temporary increase in pain and a brief, temporary increased need for treatment, but in most every case there are no long-term effects to the patient. These problems occur so infrequently and are so rare that there are no available statistics to quantify their probability.

**Rib Fracture**: Rarely, chiropractic adjustment(s) may crack a rib bone. This risk is increased in elderly, osteoporotic bones. We adjust all patients very carefully, especially our elderly patients with osteoporosis. These problems of rib fracture occur so rarely that there are no available statistics to quantify their probability.

**Soreness**: Chiropractic adjustments, traction, massage therapy, exercise, etc. may result in temporary increase in soreness. This is usually a very temporary symptom. It is not dangerous, but please tell Dr. Fox about it.

**Stroke**: Stroke is VERY uncommon, but it is the most serious problems associated with vertebral manipulation of the cervical spine (neck). In the May, 1994 Chiropractic Report, they discuss the problem. “By any medical standard, chiropractic cervical adjustment is an extremely safe treatment. Vertbral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002% or one case in two million.” In another study, (Journal of CCA, Vol. 37, No. 2, June 1993) they estimate that the risk of this type of stroke is .0003%, one in three million.

**Other Problems**: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Medical Information Consent Form - HIPPA

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations, of our practice. HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESTRICTIONS:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practice. These changes in our office’s policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

~Dr. Brandon D. Fox, D.C. and Staff