CONFIDENTIAL PATIENT PROFILE

Name: _____ M____ F____ Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Work Phone: _____

Marital Status: M S W D Spouse's name: _____ # of Children: _____

Birthdate: _____ Age: _____ Email address: _____

Occupation: _____ Employer: _____

Reason for this visit: _____
Is current illness/injury due to (circle one) an accident, work related or other?
Explain: _____

Previous Chiropractic care? Y N Where: _____ Last visit: _____

Current MD: _____

Emergency contact: _____ Phone: _____

WHO DO WE THANK FOR YOUR REFERRAL? _____

Do you have health insurance to help you pay for your care? Y N
Name of insurance company: _____

AUTHORIZATION & ASSIGNMENT

I hereby authorize **Dr. Kayla Ranger-Dean, DC** to release any information appropriate concerning my physical condition to my insurance company, or an adjuster for reimbursement of charges incurred by me for Chiropractic care rendered me by her or any staff member acting on her behalf. I hereby authorize my insurance company to pay **Dr. Kayla Ranger-Dean, DC/Mattawan Chiropractic Clinic, PC** directly for any Chiropractic care I have received.

I also understand that I am responsible for paying my **Insurance Deductible or Copay** to **Dr. Kayla Ranger-Dean, DC/ Mattawan Chiropractic Clinic, PC** and in the event that my insurance company does not pay for my care, I am responsible for paying the balance on my account.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

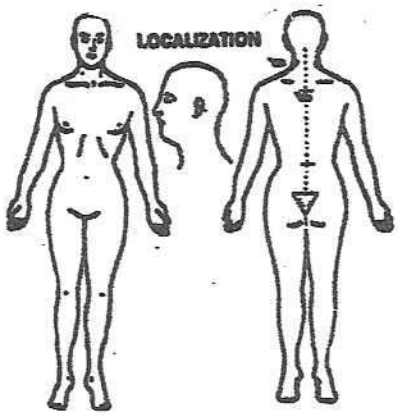
Name: _____ Date: _____ Patient #: _____
(office use only)

PATIENT INFORMATION/FAMILY HISTORY

Below are conditions which may seem unrelated to the purpose of your appointment. However, the questions must be answered carefully as these conditions can affect your overall course of Chiropractic care. Circle any/all that apply to you.

Allergy	Alcoholism	Asthma	Arthritis
Backaches	Cancer	Chicken Pox	Colitis
Constipation	Depression	Diarrhea	Diabetes
Dizziness	Ear Infections	Epilepsy	Headaches
Heartburn	Heart Attack	Heart Disease	High Blood Pressure
Measles	Menstrual cramps	Migraines	Multiple Sclerosis
Miscarriage	Mumps	Nausea	Painful Urination
Polio	Prostate	Sleep Loss	Rheumatic Fever
Stress	Stroke	Swollen Ankles	Thyroid Problems
Ulcers	Whopping Cough	Other: _____	

Mark on this body where you are having pain or discomfort:



Family History: Please write any conditions your family has had:

Mom: _____
Dad: _____
Sisters: _____
Brothers: _____

Surgery or Operations:

Back	Heart	Gall Bladder	Hernia	Appendix	Tonsils
Prostate	Hysterectomy	Knee	Hip	Shoulder	Other: _____

Mediations you are taking:

Blood Pressure	Pain Killers	Muscle Relaxers	Mood Altering	Insulin
Synthroid	Aspirin	Birth Control	Other: _____	

Past accidents:

Car/Truck – When _____ Rearended Head-on Tboned Rollover (circle one)
Car/Truck – When _____ Rearended Head-on Tboned Rollover
Job related – When _____ What _____
Other – When _____

Pain Rating Scale: Please circle one:

0 1 2 3 4 5 6 7 8 9 10
None Moderate Worst ever

Patient signature: _____

Dr. Kayla Ranger-Dean, D.C.

Mattawan Chiropractic Clinic, P.C.
55475 N. Main St.
Mattawan, MI 49071
269-668-4521
fax: 269-668-4522

PRIVACY POLICY FOR MATTAWAN CHIROPRACTIC CLINIC, PC

I acknowledge that I was offered a copy of **Mattawan Chiropractic Clinic, PC's "Notice of Privacy Practice"** policy. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at **Mattawan Chiropractic Clinic, PC.** The Notice of Privacy Practices for **Mattawan Chiropractic Clinic, PC** is also provided on request at the administration desk of this practice and on the practice website at **Mattawanchiropractic.com.** This Notice of Privacy Practices also describes my rights and **Mattawan Chiropractic Clinic, PC's** duties with respect to my protected health information.

Mattawan Chiropractic Clinic, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website **Mattawanchiropractic.com,** calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Mattawan Chiropractic Clinic, PC or Dr. Kayla Ranger-Dean, DC** has taken action in reliance on the consent.

_____ Date: _____

Signature of patient or personal representative

_____

Name of patient or personal representative

_____

Description of personal representative's authority