

Chart# _____

NEW PATIENT INFORMATION

Last Name _____ Legal First _____ Middle Initial _____

Sex: M F Birthdate: ___/___/___ Single Married Widowed Divorced Separated

Home Phone#: _____ Cell#: _____

Can we leave a message? Y N Email: _____

Address: _____
street city state zip

Emergency Contact Name: _____ Relationship: _____
Phone#: _____

Occupation: _____

Employer: _____ Work#: _____

Briefly describe symptoms: _____

Have you seen any other doctor for this condition? Yes No

Check conditions you have or have had in the past:

- | | | | | |
|---|--|---|-------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Backaches | <input type="checkbox"/> Numbness | <input type="checkbox"/> Anemia | |

Have you had any operations? Yes No What Kind? _____

Are you allergic to any medications? Yes No What Kind? _____

Are you taking any medications? Yes No What Kind? _____

Are you pregnant? Yes No Date of Last Menstrual Period? _____

Are you a smoker? Yes No How Often? _____

Do you drink alcohol? Yes No How Often? _____

Patient Name: _____ Chart# _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures etc. on me (or patient named below, for whom I am legally responsible) by Dr. Lubovich and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome. Diaphragmatic paralysis, cervical myelopathy and costo- vertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

MY PRIVACY

I have had access to a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditations.

FINANCIAL RESPONSIBILITY

I understand and agree that all health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that I am financially responsible for all services not paid for by my insurance. I am also responsible for any deductibles, copayments required by my insurance plan.

MY CERTIFICATION

I certify that the information on this form is correct and I request services.

Patient Signature or person acting on patient's behalf

Date

Witness (staff use only)

Date