Chiropractic Case History / Patient Information

Dr. Benjamin Wilson

Appointment:_____ **Today's Date:** _____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Have you ever received Chiropractic Care? Yes No If yes, when_____

Where_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Location of complaint: _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No Where?_____

Do you have any numbness or tingling in your body? Yes No Where?_____

What does this prevent you from doing or enjoying?_____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to your major symptom?Yes _____ No _____.

If yes, describe: _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

Date symptoms appeared or accident happened:_____

List any major accidents you have had other than those that might be mentioned above:

_____

Is this due to: Auto___ Work____ Other_____

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

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls?_____

_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

WOMEN ONLY:

Females/Pregnancies and outcomes:

Pregnancies / Date of Delivery	Type of Delivery	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What was the date of the beginning of your last mentrual period? _____

Are you pregnant or is there any possibility you may be pregnant?

Yes _____ No _____ Uncertain _____

Remarks: _____

Medications:	**Reason for taking**
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to any medications? Yes No

If yes, describe:_____

Do you have any allergies of any kind? Yes No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

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

If yes, describe:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Deaths in immediate family:_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

Social and Occupational History:

A. Level of Education: High School some college college graduate post graduate studies

B. Job Description_____

C Work Schedule:_____

D Recreational activities:_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

INSURANCE

Please circle 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

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Doctors Signature: _____ Date:_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date
Dr. Ben Wilson DC	Benjamin Wilson DC	

East Texas Family
CHIROPRACTIC

ASSIGNMENT OF BENEFITS

Name of Insured (Print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related products or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insuer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payments for products received.

East Texas Family Chiropractic
3320 Troup Hwy Ste 240
Tyler, TX. 75701

Name of person signing (Print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

East Texas Family
CHIROPRACTIC

MISSED APPOINTMENT POLICY

We want to thank-you for choosing us as your chiropractic health provider. Your body heals in rhythms, and it is important to make your health a priority by keeping all scheduled appointments. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments.

We have reserved appointment times especially for you, and do not book any other patients at your appointment time, so we request 48 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses, you, the doctor, and the other patients that would like to have utilized your appointment time.

We understand that situations come up sometimes and appointments cannot be kept. Our office does not normally charge for broken or cancelled appointments, however, should it become a problem we do reserve the right to charge a $60.00 missed appointment fee. This will be your responsibility and will not be bill to any insurance companies. Please make your health a priority, keep your reserved time.

Thank you for your consideration of our policies, and for the opportunity to be your chiropractic office of choice.

Name (Print):_____

Signature: _____ **Date:** _____

East Texas Family Chiropractic
3320 Troup Hwy Ste 240
Tyler, TX. 75701

Acknowledg[illegible]t for Consent to Use and Disc[illegible]re of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by East Texas Family Chiropractic *(Clinic Name)* or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative to Patient

Ben Wilson, DC

Office Representative Date

Others we may release your PHI to

East Texas Family Chiropractic
3320 Troup Hwy Ste 240
Tyler, TX. 75701
903-535-9355

East Texas Family Chiropractic does not bill any insurance companies for the following:

Acupuncture
Acupuncture exam
Acupuncture scan
Laser treatment

I _____ acknowledge that East Texas Family Chiropractic will not bill any insurance company for the services listed.
I understand that I am responsible for payment in full for these services. Should I choose to bill any insurance company for these services I accept the amount reimbursed by my insurance as payment in full, and East Texas Family Chiropractic is not responsible to refund any differences of the amount charged and the amount reimbursed by insurance.

Acupuncture pre-pay packages:
We offer some pre-pay packages for acupuncture that gives a discount when purchased in advance. ETFC will offer a refund of any package if not used within one year, however, the full price will be charged for each treatment used and the balance will be refunded to the patient within 7 days. Packages are only good for one year from purchase.

_____	_____	_____
Print Name	Signature	Date

EHR Certification – Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: *(To be entered in EZnotes through "Edit Patient Info")*

Name: (Print clearly) _____ **Today's Date:** _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

What is your preferred method of contact? Only 1 method of contact needed

Home	Work	Cell

Phone Number: _____

Phone Call: ☐ Text Message: ☐

E-Mail: _____

Mailing Address: _____

_____

_____

OFFICE USE ONLY

***Vitals:** In EZnotes, complete by*

1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ **Height:** _____ **Weight:** _____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication:		

Are you allergic to any medicines? Please list each drug on a new line:
Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

***Timely access:** In EZnotes, complete by*

1) Going to "Edit Patient" section for this patient
3) Select "Asked Timely Access"

☐ Completed?

***Medications:** In EZnotes, complete by*

1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

Entered into EZnotes by (name): _____ Date & Time: _____

☐ Completed?