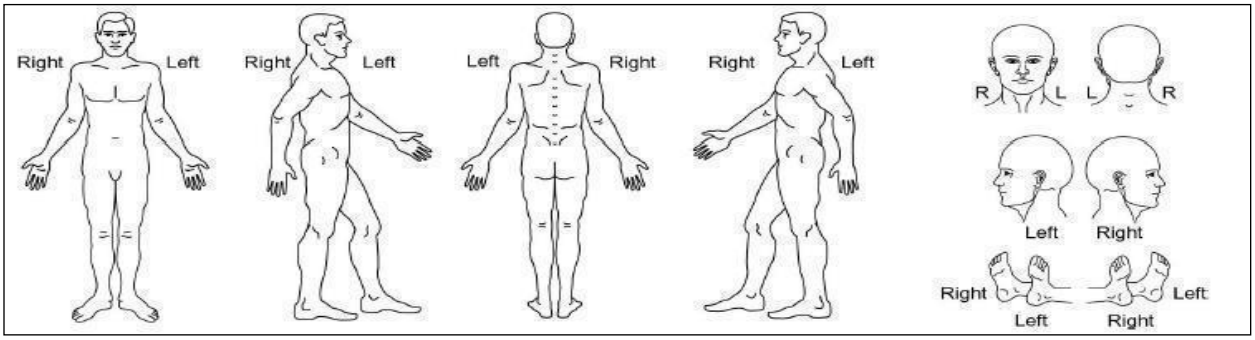
Fangman Family Chiropractic 200 SE Gateway Ste 103, Grimes, IA, 50111 515-986-4003			
First Name:	Middle:	Last Name:	
Guardian's Name (if applicable)	First Name:	Last Name:	
Today's Date:	Social Sec #:	Birthdate:	
Sex M F Ht: Wt: BP:	Single / Married	Children:	
Cell#:	Work#:	Home#:	
Address (City):		State:	Zip:
Em Contact:	Relationship:	Phone:	
Email:	Referred by:	Previous Chiro:	
Employer:	Address:	Duties:	

Primary Complaint:		
When did you first notice it?	What were you doing?	
Where is the symptom?	Where does it travel?	
Sharp Dull Aching Burning Numb Throbbing Radiating	☺ 1-2-3-4-5-6-7-8-9-10	When 25% 50% 75% 100%
What makes it better?	What makes it worse?	
Difficult movements?	Difficult activities?	
What have you tried?	Have you had this symptom before?	
List additional complaints:		

History				
0 Allergies	0 Cancer	0 Fatigue	0 Kidney Stones	0 Short of Breath
0 Alcoholism	0 Chest Pain	0 Frequent Urination	0 Loss of Balance	0 Sinus Infection
0 Anemia	0 Cold Extremities	0 Irregular Menstrual	0 Loss of Memory	0 Spinal Curvatures
0 Arteriosclerosis	0 Constipation	0 Hemorrhoids	0 Loss of Smell	0 Stroke
0 Arthritis	0 Cramps	0 High Blood Press	0 Loss of Taste	0 Swelling of Ankles
0 Asthma	0 Depression	0 Insomnia	0 Nosebleeds	0 Swollen Joints
0 Back Pain	0 Diabetes	0 Irreg Heart Beat	0 Pacemaker	0 Thyroid Condition
0 Breast Lump	0 Digestion Trouble	0 Headache	0 Poor Posture	0 Tuberculosis
0 Bronchitis	0 Dizziness	0 Hot Flashes	0 Prostate Trouble	0 Ulcers
0 Bruise Easily	0 Eye Pain	0 Kidney Infection	0 Sciatica	0 Varicose Veins

Medical History	Father	Mother	Siblings	Children
Preferred method of communication: Email / Phone / Mail			Preferred Language:	
Smoking Status: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked				
American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /Pacific Islander / I Decline				
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer				
Medications/Purpose:				
Allergic Reactions to Medicine:				



I certify that I am the patient or guardian listed above. I have read/understood the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of this information in this office.	
Patient's Signature:	Date:

Fangman Family Chiropractic Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic adjustments are performed in our office by skilled Doctor of Chiropractic who have successfully completed advanced educational requirements, national board examinations, and state boards examinations. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible the risk is minimized to its lowest level. Our doctors and staff make every effort possible to provide the safest chiropractic care available. The undersigned hereby consents that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-ray Release

This is to certify that Dr. Fangman has my permission to perform an X-ray evaluation. **To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.** Date of last menstrual period:

Consent to Care for Minor

I authorize Dr. Fangman to administer care as he so deeds necessary to my son/daughter.

Payment / Insurance

I understand that Dr Fangman will provide a receipt to assist me in making collection from any insurance company. I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 21% and sent to collections past 90 days.

I have read and understand the above and I agree to these policies and procedures.

☐ Terms of Acceptance ☐ Patient Health Information Consent Form ☐ X-ray Release ☐ Minor Consent

Signature:_____ Date:_____