

Confidential Patient Record

Patient Information	nformation	Patient
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Name:

Address:

SSN #:

Home #:_____

Cell #:

Email:

Can we text and email you? Yes No

Gender: M F

Age: _____ DOB: ___/___/

Single Married Widowed Separated Divorced

Who referred you?____

Occupation:

Employer:

Emergency Contact

Name:

Relationship: _____

Phone #:_____

Insurance Information

Subscriber:

Relationship: _____

DOB: ___/___/

Insurance Company:

ID#:_____

GRP#:_____

Is patient covered by additional insurance? Yes No

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with ____ and assign directly to the doctors of Clarrey Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I clearly understand and agree that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party's Signature

Relationship

Date

Major symptoms/complaints:	Confidential Patient History								
How did your symptoms start?	Major symptoms/compl	aints:							
Average pain intensity: Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain How often do you experience your symptoms? Constanty (76-100% of the time) Direquently (51-75% of the time) Describe the nature of your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Describe the nature of your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Describe the nature of your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Describe the nature of your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Diverse your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Diverse your symptoms: Charaction (76-100% of the time) Direction (76-100% of the time) Direction (76-100% of the time) Ingeneral, how would you say your overall health is right now? Deoor Have you been to a chiroparactor before? When was your last vist? Major injuries or surgeries:	(ma)								
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Medications & Usage:	Have you been to a chiro	practor before? When was your las	t visit?						
Medications & Usage:	Major injuries or surger	ies:							
Family doctor:	Medications & Usage:								
Review of Systems Please check conditions or symptoms you currently have or have had in the past: DAIDS/HIV Epilepsy Depilepsy Dipession Depilepsy Dipession Depilepsy Dipession Depilepsy Dipession Depilepsy Dipession Depilepsy Dipession Depilepsy D									
Review of Systems Please check conditions or symptoms you currently have or have had in the past: DAIDS/HIV Epilepsy High Blood Pressure DMultiple Sclerosis DScarlet Fever DArthritis Eye Problems High Cholesterol DNausea DSpinal Conditions DAsthma Goiter Daw Pain/TMJ DNeurological Problems Dstroke Balance Impaired Gout Kidney Disease Osteoporosis Thyroid problems Burning Eyes Headaches Knee Pain Pacemaker Tuberculosis Cancer Hearing Problems Lightheadedness Parkinson's Tumors/growths Diabetes Heart Attack Diver Disease Plothed Nerve Ulcers Diabetes Hepatitis Dloss of Grip Pneumonia Dvaricose Veins Dizziness Hepatitis Dloss of Memory Prostate problems Other	Have you been in an auto accident or any other personal injury? When? Describe:								
Please check conditions or symptoms you currently have or have had in the past:									
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Printed Patient Name Patient or Responsible Party's Signature Date									

HIPAA Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Clarrey Chiropractic's 'Notice of Privacy Practices'. This Notice describes how Clarrey Chiropractic may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the consent.

Informed Consent

I hereby authorize the doctor to examine and treat my conditions deemed appropriate through the use of chiropractic care, and I give authority for those procedures to be performed. I understand that chiropractic is not an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses judgment to anticipate or explain risks and complications and an undesirable result does not indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

Authorization

I give Clarrey Chiropractic the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Clarrey Chiropractic, for any professional services.

MY SIGNATURE IS AN ACKNOWLEGEMENT THAT I HAVE READ AND UNDERSTAND THE POLICIES ABOVE AND AGREE TO ABIDE BY SAME

Cancellation /No Show Policy for Doctor Appointments and Massage

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

IF AN APOINTMENT IS NOT CANCELLED BY 5PM THE DAY PRIOR TO TREATMENT, YOU WILL BE CHARGED A TWENTY-FIVE (\$25) FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

Print Name:							
Signature:			Date:				