Port City Chiropractic, PC
Dr. Edward J. Galvin, Jr.

PERSONAL INFORMATION

Name:_____ Age:_____ Date of Birth: ____/____/____

Address:_____
Street/Road City State Zip

Sex: ☐M ☐F Preferred Language: ☐ English ☐ Other:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced No. Of Children:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

Would you like appointment reminders via text?: ☐Y ☐N If Yes, Cell Phone Carrier:_____

E-Mail Address:_____
We use e-mail for appointment reminders, periodic office updates and monthly wellness information

Race: ☐ Caucasian / White ☐ Hispanic or Latino ☐ African American ☐ American Indian ☐Multi-Raced
☐ Native Hawaiian or Pacific Islander ☐ Other:_____

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Phone #:_____

In Case Of Emergency, Contact:_____ Phone #:_____

Emergency Contact's Relationship to You:_____

Name of Primary Care Physician:_____ Last Seen:_____

How Were You Referred To Our Office (*For New Patients*):_____

Certification

➢ ***1.*** *I hereby state that all of the above information is complete and truthful.* ***2.*** *I hereby authorize the doctor to treat my condition, as they deem appropriate through the use of chiropractic health care.* ***3.*** *I have been advised of my financial responsibility and I fully understand and agree that all fees incurred in this office, regardless of my insurance coverage, are my responsibility.* ***4.*** *If my insurance company requests information in order to process a claim that I have sent to them for processing/payment, I give my permission for such information to be released to the insurance company.*

_____ _____
SIGNATURE OF PATIENT DATE

Medicare

Are You Covered By Medicare? ☐ Yes ☐No Is This a Medicare Advantage Plan? ☐Yes ☐No

If Yes, please read and sign below.

I understand and agree to the following: (1) I am responsible for paying all fees for services at the time of every visit. (2) I understand Port City Chiropractic PC, will send the claims to Medicare on my behalf and claims for secondary / supplemental insurance companies will be forwarded on from Medicare. (3) I understand I am responsible for submitting Medicare Advantage Health Plan claims. (4) Any reimbursement from my insurance companies will be sent to me directly. (5) I give permission for Port City Chiropractic PC to forward any information to my insurance company(s) if necessary for consideration of payment.

_____ _____
SIGNATURE DATE

Case History

Patient Name:_____ **Age:**_____ **Date of Birth:**_____

Height: _____ **Weight:** _____

Please list the primary reason for your visit to our office: _____

_____

Have you lost any time from work due to your current condition? ☐No ☐Yes
Date(s) out of work:_____ Date Returned:_____ ☐Have not returned

☐Work Injury ☐ Auto Accident ☐Other:_____

Have you had any treatment for your current condition:
☐NONE ☐Chiropractic Treatment ☐Physical Therapy ☐Orthopedic Evaluation ☐Neurosurgical Evaluation
☐Neurological Evaluation ☐Pain Management ☐Massage Therapy ☐Acupuncture
☐Other:_____

List all recent diagnostic testing for current condition:
☐X-Ray ☐MRI ☐CT Scan ☐NCV/EMG ☐Other:_____
☐Where Done:_____

<u>Illnesses:</u> Please list all significant illness you've had:
☐None ☐List:_____
_____

<u>Injuries:</u> Please list all significant injuries you've had:
☐No Significant Injuries:_____
☐Spine Injuries:_____
☐Auto Accident:_____
☐Work Injury:_____
☐Fractures/Dislocations:_____
☐Falls:_____
☐Head Injury:_____
☐Other:_____

<u>Surgeries:</u> Please list all surgeries and dates:
☐None ☐List:_____

<u>SOCIAL HISTORY:</u>

<u>Employment:</u>
☐Working ☐Not Working ☐Retired ☐Disabled ☐Stay @ Home Parent ☐Student

<u>Tobacco Use:</u>
☐Never Smoked ☐Current Smoker ☐Former Smoker ☐Vape ☐Nicotine Patch ☐Chew Tobacco ☐Other
___ Every day
___ Occasional

<u>Substance Use:</u>
Alcohol: ☐NONE ☐Social Drinker ☐Other:_____

Please list all drug <u>allergies</u>:
☐None ☐List:_____

Please list <u>all</u> Medications/Supplements currently taking:
☐NONE ☐See Attached List
☐List:_____
_____

<u>Female Only:</u>
Are you pregnant? ☐NO ☐YES If Yes, Due Date:_____

OVER ⟶

Rev 2/2020

REVIEW OF SYSTEMS

Constitutional:
☐None
☐Fever
☐Chills
☐Night Sweats
☐Weight Loss
☐Fatigue
☐Weakness

Musculoskeletal:
General
☐None
☐Migratory Pain
☐Neck Pain
☐Mid Back Pain
☐Low Back Pain

Abnormal Muscles
☐None
☐Weakness
☐Muscle Wasting
☐Loss of Motion
☐Stiffness

Neurological:
Autonomic
☐None
☐Incontinence
☐Abnormal Sweating

Cranial Nerves
☐None
☐Balance Problems
☐Changes in: Speech, Swallow, Taste
☐Loss of Smell
☐Hearing Aids ☐Both ☐L ☐R
☐Visual Changes (Blurred Vision, Double Vision)

Neurological (cont.):
Head
☐None
☐Headaches: Tension, Migraine, Cluster
☐Vertigo
☐Fainting (syncope)
☐Confusion
☐Memory Loss

Endocrine:
☐None
☐Diabetes
☐Thyroid Disease
- ☐Hypothyroidism
- ☐Hyperthyroidism
- ☐Goiter
- ☐Hashimoto's Thyroiditis

☐Excessive Thirst
☐Heat/Cold Intolerance

Cardiovascular
☐None
☐Shortness of Breath w/exertion
☐Tightness in Chest
☐Palpitations
☐Cold Extremities
☐Hypertension (High Blood Pressure)
☐Hypercholesterolemia (High Cholesterol)
☐Atrial Fibrillation (A-fib)

I hereby state that all of the information I have provided is complete and truthful.

SIGNATURE OF PATIENT / PARENT / GUARDIAN _____ DATE _____

Port City Chiropractic, PC

Dr. Edward J. Galvin, Jr.
335 West 1st St.
Oswego, NY 13126
315-342-6151

Authorization for Release of Information & Notice of Privacy Practices

Patient's Name:_____ **Date of Birth:**_____

- I authorize Port City Chiropractic, PC (PCC) to release protected health information, if necessary, about the above-named patient to the people named below.
- I understand that PCC may need to discuss my medical condition and may need to share my medical records with any physician, family member, or other health care provider who is involved in my care.
- PCC may leave messages (for appointment reminders, lab, x-ray, or other test results) on my telephone answering machine at my:

Home #:_____ ☐Y ☐N ***Cell#:***_____ ☐Y ☐N

Work#:_____ ☐Y ☐N

Please make sure we have <u>all</u> of your updated phone numbers

- If necessary, PCC may talk with my spouse/significant other, parents, family member, or my caretaker about my medical condition (for appointment reminders, lab, x-ray, or other test results) and / or billing information. Please list these people below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

- I was notified that a copy of the PCC ***Patient Privacy Notice*** is available for review in the office or I am able to receive a copy by mail/e-mail if requested.
- I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification. I understand that any change in this authorization is effective from the date signed going forward.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

_____

Signature (Patient/Parent/Guardian) Date