For Office use only *ID* _____
Blood Pressure: _____ Pulse: _____

Georges' Chiropractic & Wellness Center
1400 N. Zaragoza Rd. Ste D
El Paso, Texas 79936
Phone: 915-592-3333
Fax: 915-592-1440

New Patient Intake Form

Name _____**DOB** _____**AGE** _____

Address _____**City** _____**State** _____**Zip**_____

Home Phone _____**Email Address** _____

Race: *(circle one)* ***American Indian or Alaska native/ Asia/ Black or African American/ White (Caucasian) Native Hawaiian or Pacific Islander/ I Decline to Answer***

Ethnicity: *(Circle one)* ***Hispanic or Latino / not Hispanic or Latino / I decline to Answer***

Marital Status: *(Circle one)* ***M/ S/ D/ W*** **# Of Children** _____ **Ages:** _____

Occupation: _____ **Place of Work:**_____**Work Phone #:**_____

Emergency Contact _____**Ph#** _____ **Relationship:**_____

Referred by _____.

Reason for visit: _____

Health Information

Have you received previous chiropractic care? _____

Have you had this similar condition in the past? _____

What activities aggravate this condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Is this condition interfering with your Work ☐ Sleep ☐ Daily Routine ☐ Other _____

How long has it been since you've felt well? _____

Have other Doctor's treated this condition? Yes ☐ No ☐ Who?_____

Age of Mattress: _____ **Comfortable ☐ Uncomfortable ☐**

Do you wear: Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ N/A ☐

Smoking Status *(Circle one):* ***Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked***

Smoking Start Date *(Optional):* _____

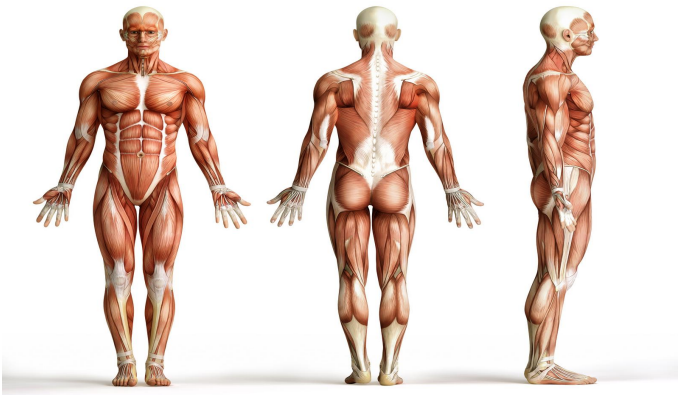
Are you currently taking any medication?

Medication Name	Dosage and frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional comments

Please mark the areas of your pain on the figures below.



Medical History

Have you been involved in an auto accident or have had any other personal injuries?

Past year ☐ Past 5 yrs ☐ Over 5 yrs ☐ Never ☐

Describe the accident

_____

_____

Date of last physical examination_____

Have you ever suffered from the following conditions?

Dizziness ☐ Backaches ☐ Heart Trouble ☐ Diabetes ☐ Arthritis ☐ Headaches ☐

Asthma ☐ Neuritis ☐ Digestive Disorders ☐ Nervousness ☐ Sinus Trouble ☐ Neck Pain ☐

List surgical procedures and year _____

Family Medical Information: (Many health problems are the result of hereditary spinal weaknesses, thus information about your family members will give us a better understanding of your total health condition).

Name	Relation	Past & Present Health Problems

Insurance Information

Is your condition due to an auto accident or to a job related injury? Yes □ No □ Are you insured? Yes □ No □

If yes, name of Insurance Company_____ Policy # _____

Are you covered by Medicare? Yes □ No □ If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that George's Chiropractic & Wellness Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered will be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

____I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____ Date _____

If we do not sincerely believe your condition will respond satisfactory, we will not accept your case.
Thank You.

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Georges' Chiropractic & Wellness Center, we may use or disclose personal and health related information about you in the following ways.

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party such as an insurance carrier, a HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and health care records may be used to contact you regarding appointment confirmations, information about alternatives to your present care, or other health related information that may be of interest to you.
- Your information may be visible to other patient's as we utilize a front sign in computer to record your arrival.
- We utilize open adjusting room in our office. We may utilize a closed adjusting room at patients request.

If you are not at home to receive an appointment confirmation, a message may be left on your answering machine or voicemail. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances.

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like to receive this information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use of disclose based on this privacy notice may be used subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a concern regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your concerns to:
Dr. Thomas Georges.

If you would like further information about our privacy policies and practices please contact Dr. Thomas Georges.

This notice is effective as of _____This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed Please) **Signature** **Date**

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative (Print) **Signature** **Date**

Description of the authority to act on behalf of the patient.