

PATIENT INFORMATION

Name _____ Date: _____
Sex: ☐ M ☐ F Birthdate _____ Age _____ E-mail _____
Address _____ City _____ ST _____ Zip _____
Home Phone _____ Cell _____ Work _____
Best time and place to reach you: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Occupation _____ Employer Name _____ Phone#: _____
Employer Address _____ City _____ St _____ Zip _____
Spouse's Name _____ Birthdate _____ Spouse's Employer _____
IN CASE OF EMERGENCY, CONTACT: Name _____ Relationship _____
Home Phone: _____ Cell _____ Work _____

Reason for your visit: _____

When did your symptoms appear? _____ Is condition getting worse? ☐ Yes ☐ No ☐ Unknown What previous treatment have you received for this condition? ☐ Chiropractic Care ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ None ☐ None ☐ Other _____

Name and Phone Number of other doctor(s) who have treated you for this condition: _____

Date of last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Blood Test _____
Chest X-ray _____ Urine Test _____ Dental X-ray _____ MRI, CT Scan, Bone Scan _____

PLEASE CHECK "YES" OR "NO" TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

EXERCISE

☐ None ☐ Moderate
☐ Daily ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Light Labor
☐ Standing ☐ Heavy Labor

HABITS:

Water _____ Cups/day Smoking _____ Packs/day
Alcohol _____ Drinks/week Coffee/Caffeine Drinks _____ Cups/day
☐ High Stress Level – Reason _____

INJURIES/SURGERIES**DESCRIPTION****DATE**

Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Surgeries _____

*Females Only – Are you pregnant? ☐ Yes ☐ No If yes, due date _____

MEDICATIONS: _____

ALLERGIES: _____

VITAMINS/HERBS/MINERALS: _____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

- 1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
- 2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
- 3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
- 4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature

Patient Name (Please Print)

Witness Signature

Date

Precision Health Care Center
Dr. David Tejada D.C
2166 Ogden Ave Aurora, IL 60504

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 Precision Health Care 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, an 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 your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. 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 provide to you or the 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 your 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 the 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 for 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. If changes are made to our 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 or disclose based on this privacy notice may be 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 complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: _____.

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

Personal Representative Printed

Personal Representative Signature

Date

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

LETTER OF NO ACCIDENT OR WORK INJURY

Patient's Name

Dear Insurance Company,

This letter is to inform you that I was not involved in any auto or work injury for this diagnostic test and/or treatment.

Please note the following:

I _____ state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of any injury while on the job or by any other person related to my employment.

Please process my claim properly with no delay!

Sincerely,

Patient's Name

SIGNATURE ON FILE

- ☒ I authorize use of this form on all my insurance submissions.
- ☒ I authorize release of information to all my Insurance Companies.
- ☒ I understand that I am responsible for my bill.
- ☒ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ☒ I authorize payment direct to my doctor.
- ☒ I permit a copy of this authorization to be used in place of the original.

Name: _____ SS#/Medicare#: _____
(Please Print)

Signature: _____ Date: _____