Fargo SPINE

Chiropractic Case History/Patient Information

Date: _____ Email Address:_____

Name: _____ Cell Phone:_____

Cell Phone Carrier: AT&T VERIZON SPRINT TMOBILE OTHER: _____

SSN: _____ Age: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Sex: M F Marital Status: M S W D

Spouse: _____ Spouses DOB: _____

If Minor - Parent Name: _____ Parent DOB: _____

Employer: _____ Occupation:_____

Office Phone Number: _____

Emergency Contact: _____ Phone: _____

How were you referred to our office: _____

Please circle any and all insurance coverage that may be applicable in this case:

Medical Workers Compensation Auto Accident

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint and purpose of this appointment: _____

_____

Is this due to: Auto Work Other Date symptoms appeared or accident: _____

Have you ever had the same or similar condition? Y N If yes, when and describe:

_____

Date of last physical: _____ History of: High Blood Pressure or Stroke

Past major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates:) _____

_____

CHECK WHICH SYMPTOMS YOU ARE EXPERIENCING

_____ Headache	_____ Sleeping Problems	_____ Loss of Balance
_____ Neck Pain	_____ Pins & Needles	_____ Cold Sweats
_____ Dizziness	_____ Numbness	_____ Poor Circulation
_____ Back Pain	_____ Depression	_____ Shortness of Breath
_____ Tension	_____ Irritability	_____ Loss of Memory
_____ Fatigue	_____ Chest Pain	_____ Neck Stiffness
_____ Fainting	_____ Ears Ringing	_____ Light Sensitivity
_____ Fever	_____ Nervousness	_____ Other

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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.

The following person(s) have my permission to receive my personal health information:

_____

_____

By signing this statement you understand the above information and guarantee this form was completed correctly to the best of your knowledge. You understand it is your responsibility to inform this office of any changes in your personal, medical, or insurance status. You hereby authorize assignment of your insurance rights and benefits directly to the provider for services rendered. You understand that you are ulimately responsible for the balance due, regardless of the insurance companies' policies.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____