CHIROPRACTIC NEW PATIENT PAPERWORK

File #_____

Patient Information

Date _____

Name_____

Address_____

_____

City State Zip

Date of Birth_____ Age_____

Gender: ❍ Male ❍ Female

Contact Information

Home_____

Cell_____

E-mail Address_____

In Case of Emergency, Contact

Name_____

Relationship_____

Home Phone_____

Other Information

Occupation_____

Employer_____

Marital Status: ❍Single ❍ Married ❍Divorced

Spouse's Name_____

Spouse's Birthdate_____

How did you hear about our clinic?_____

Whom may we thank for referring you?_____

_____

Billing Information

❍ **Insurance** ❍ **In-House Discount Plan** ($40 & under)

Policy Holder_____

Relationship_____ B-day_____

Gender: ❍ Male ❍ Female

Employer_____

Phone # _____

Insurance Co._____

ID #_____

Group/Policy #_____

Patient Signature

_____

Condition History

When did your condition appear?_____

Is current condition due to an injury? ❍ Yes ❍ No

Type of Accident? ❍Auto ❍At Work ❍Home ❍Other

To whom have you made a report of your accident?

❍Auto Insurance ❍Employer ❍Work Comp ❍Other

Have you seen anyone else for this problem?

❍ No ❍ Yes If yes, who?_____

_____

Phone Number_____

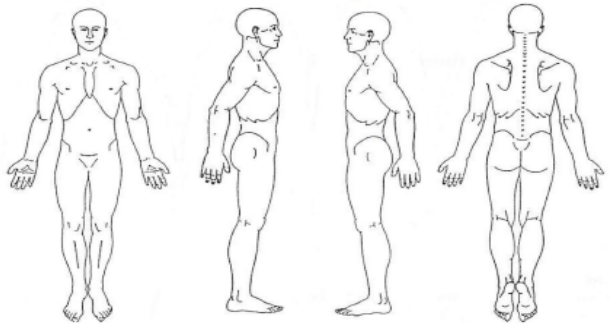
Have you ever been disabled? ❍ No ❍ Yes

If yes, when and how?_____

Condition Information

Reason for Visit_____

Is current condition getting worse? ❍ Yes ❍ No ❍ Unknown

Please mark the intensity of your pain	Please mark area & type of pain using the code below
1=no pain and 10= most intense pain ever felt Example *Neck* 1 2 3 4 5 6 7 8 9 10 Area#1: 1 2 3 4 5 6 7 8 9 10 Area#2: 1 2 3 4 5 6 7 8 9 10 Area#3: 1 2 3 4 5 6 7 8 9 10	N= Numbness, P= Pain T= Tingling, A=Ache S=Soreness, ST=Stiffness 

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What is your: height:_____ weight:_____

Exercise Level: ❍ None ❍ Minimal ❍ Moderate ❍ Strenuous ____ times/week Type:_____

Regular Habits: ❍ Smoking ____Packs/Day ❍Alcohol _____Drinks/Day ❍Caffeine _____ Cups/Day

Please circle "past" and/or "now" for each item below that applies to your health:

		General			Digestion			Eye/Ear/Nose/Throat			Respiratory		
Past	Now	Allergy _____	Past	Now	Belching/Gas	Past	Now	Asthma	Past	Now	Chest Pain/Tightness
Past	Now	Chills	Past	Now	Colon Trouble	Past	Now	Tonsillitis	Past	Now	Chronic Cough
Past	Now	Convulsions	Past	Now	Constipation	Past	Now	Sinusitis	Past	Now	Difficulty Breathing
Past	Now	Dizziness	Past	Now	Diarrhea	Past	Now	Allergies	Past	Now	Wheezing
Past	Now	Fainting	Past	Now	Excessive Hunger	Past	Now	Earache	Past	Now	Spitting Blood
Past	Now	Fatigue	Past	Now	Gallbladder Trouble	Past	Now	Ear Discharge	Past	Now	Phlegm Production
Past	Now	Fever	Past	Now	Hemorrhoids	Past	Now	Ear Noise	Past	Now	Bronchitis
Past	Now	Headaches	Past	Now	Jaundice	Past	Now	Frequent Colds			**Genitourinary**
Past	Now	Loss of Sleep	Past	Now	Liver Trouble	Past	Now	Hay Fever	Past	Now	Bed Wetting
Past	Now	Loss of Weight	Past	Now	Nausea	Past	Now	Hoarseness	Past	Now	Blood in Urine
Past	Now	Nervousness	Past	Now	Pain in Stomach	Past	Now	Nasal Congestion	Past	Now	Frequent Urination
Past	Now	Nerve Pain	Past	Now	Poor Appetite	Past	Now	Nose Bleeding	Past	Now	Urinary Incontinence
Past	Now	Night Sweats	Past	Now	Poor Digestion	Past	Now	Pain in Eyes	Past	Now	Kidney Infection
Past	Now	Numbness (arms, legs or hands)	Past	Now	Vomiting	Past	Now	Poor Vision	Past	Now	Painful Urination
Past	Now	Unconsciousness	Past	Now	Vomiting Blood	Past	Now	Crossed Vision	Past	Now	Prostate Trouble
		Muscles/Joints			**Cardiovascular**			**Skin**			**For Women Only**
Past	Now	Backache	Past	Now	High Blood Pressure	Past	Now	Bruise Easily	Past	Now	Cramps/Backache
Past	Now	Pain Between Shoulder Blades	Past	Now	Low Blood Pressure	Past	Now	Dryness	Past	Now	Excessive Flow
Past	Now	Stiff Neck	Past	Now	Pain over Heart	Past	Now	Eczema	Past	Now	Hot Flashes
Past	Now	Swollen Joints	Past	Now	Poor Circulation	Past	Now	Hives	Past	Now	Irregular Cycle
Past	Now	Foot Trouble	Past	Now	Heart Trouble	Past	Now	Itching	Past	Now	Miscarriage
Past	Now	Painful Tailbone	Past	Now	Rapid Heart Rate	Past	Now	Sensitive Skin	Past	Now	Painful Periods
Past	Now	Spinal Curvature	Past	Now	Slow Heart Rate	Past	Now	Skin Eruptions	Past	Now	Vaginal Discharge
Past	Now	Tremors	Past	Now	Stroke	Past	Now	Boils	Past	Now	Birth Control Medication
Past	Now	Twitching	Past	Now	Swollen Ankles				Past	Now	IUD
Past	Now	Weakness	Past	Now	Varicose Veins				Past	Now	Last Pap Exam?_____
Past	Now	Arthritis	Past	Now	Anemia				Past	Now	Pregnancy
Past	Now	Jaw Pain							Past	Now	Hormone Replacement

Have you had any of the following diseases? (circle all that apply)

Diabetes Cancer Hepatitis Tuberculosis Pneumonia Venereal Disease
Alcoholism Lupus Measles Goiter Epilepsy Polio Rheumatic Fever
Chicken Pox Pleurisy Mental Disorder Rheumatoid Arthritis Whooping Cough

Operations & Procedures:

Date	Date	Date	Date
_____ Tonsillectomy	_____ Gall Bladder	_____ Back Surgery	_____ Hernia
_____ Vaccinations	_____ Tubes in Ears	_____ Female Organs	_____ Thyroid
_____ Appendectomy	_____ Stomach	_____ Cesarean	_____ Other

Family History- Describe on the line provided below

❍ Diabetes ❍ Heart Problems ❍ Kidney ❍ Cancer ❍ Autoimmune Disease ❍ Other_____

_____ _____ _____ _____ _____ _____

Are you currently taking any medications or nutritional supplements/herbs? (please list)

_____

_____

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Please read each section thoroughly, initial each section and sign at the bottom. Thank You

_____ I have received, read and understand how my Protected Health Information will be used in this office and I agree to these policies and procedures. If I have questions or concerns about how my Protected Health Information is/will be used I understand that I may contact the Compliance Officer at the back of the Notice of Privacy Practices at any time.

Authorization to Release Information

_____ I Authorize Lauderdale Wellness Center to release all information related to the care I received to my HMO, insurance company, third party payor or their designee, other members of your healthcare team. This may be done by mail, telephone or fax. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Assignment of Benefits

_____ I assign all benefits payable to me for my care at Lauderdale Wellness Center. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. Furthermore, I understand that Lauderdale 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 to Lauderdale Wellness Center will be credited to my account on receipt. I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of Lauderdale Wellness Center. If I fail to do so, I agree that I am liable to Lauderdale Wellness Center for the interest (at a rate of 18% per annum on the balance due more than 30 days), court costs, reasonable attorney fees, and any other necessary costs to enforce payment of any part of said account(s).

Consent for Treatment

_____You have the right, as a patient to be informed about your condition and the recommended treatment to be used so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and benefits involved. This disclosure is simply meant to give you all the information, even if the risk is very remote, so that you may give or with hold your consent for the treatment.

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please feel free to speak to your practitioner.

As with any health care procedures, complications may arise during or after treatment. These complications may include soreness, muscle or ligament sprain, dislocations, fractures, disk injury or physiotherapy burn. These are extremely rare occurrences.

Authorization to Treat a Minor (under the age of 18)

_____ I hereby request and authorize Dr. Brian Malzer to perform diagnostic tests and render chiropractic adjustment and other treatments to my minor son/daughter. This authorization is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce (if applicable) separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authorization to select and authorize this care should be revoked or modified in anyway, I will immediately notify Lauderdale Wellness Center.

_____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

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LAUDERDALE WELLNESS CENTER
2443 Larpenteur Ave W
Lauderdale, MN 55113

651 917-9800

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Lauderdale Wellness Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- **You may request a restriction on the use or disclosure of your Protected Health Information.**
- **This office may or may not agree to restrict the use or disclosure of your Protected Health Information.**
- **If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.**

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	**Date**
Print Patient's Full Name	**Time**
Witness Signature	**Date**