Patient Information

Legal First Name: _____ MI: _____ Last Name: _____

Mailing Address:_____Apt: _____

City: _____ State: _____ Zip: _____

Social Security #:_____ Marital Status: S M W D Spouse:_____

Language: (Please circle one) English / Spanish / Indian / Japanese / Chinese / Korean / French/ German / Russian Other_____

Race: (Please circle one) White /American Indian or Alaska Native / Asian /Native Hawaiian or Other Pacific Islander Black or African American / Hispanic or Latino / Decline to Answer /Other_____

Ethnicity: (Please circle one) Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

DOB: _____ Age:_____ Home Phone: _____ Work Phone:_____

Cell Phone: _____ Email:_____

Please check your contact preference: _____Home _____ Work _____ Cell _____

Occupation: _____ Employer: _____

Emergency Contact:_____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Insurance Information

Who is responsible for this account? _____

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Accident Information

Is this condition due to an accident? □ Yes □ No
Type of Accident : □ Auto □ Work □ Home □ Fall □ Other Date of Accident :_____
To whom have you made a report of your accident? □Auto Insurance □Employer
Attorney Name (if applicable)_____

Patient Condition

Reason for this Appointment :_____
Other doctors seen for this condition:_____
When did this condition begin?_____
_____
Rate the severity of your pain on a scare from 1 (least pain) to 10 (severe pain)_____
Is condition getting progressively worse? □ Yes □ No □ Unknown
Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting
□Burning □Tingling □Cramps □Stiffness □Swelling □Other

Is the pain constant or does it come and go?_____
Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that worsen the pain □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other

Name and address of other doctor(s) who have treated you for your condition _____
_____

Date of Last: Physical Exam_____ **Spinal X-ray**_____ **Spinal Exam**_____
Chest X-ray_____ **MRI, CT-Scan, Bone Scan**_____

Do you have a Pacemaker or Defibrillator? _____

Place a check to indicate if you have had any of the following:

____ AIDS/HIV
____ Alcoholism
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bleeding Disorders
____ Breast Lumps
____ Cancer
____ Chemical Dependency
____ Chicken Pox
____ Diabetes □ Type 1 or □ Type II
____ Emphysema
____ Fractures
____ Goiter/Thyroid Problem
____ Gout
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herniated Disc
____ High Blood Pressure
____ Kidney Disease
____ Liver Disease
____ Migraine Headaches
____ Multiple Sclerosis
____ Osteoporosis
____ Pacemaker
____ Parkinson's Disease
____ Pinched Nerve
____ Pneumonia
____ Polio
____ Prostate Problem
____ Prosthesis
____ Psychiatric Care
____ Rheumatoid Arthritis
____ Rheumatic Fever
____ Scarlet Fever
____ Stroke
____ Suicide Attempt
____ Tuberculosis
____ Tumors, Growths
____ Ulcers

Check Any of The Following You Have or Have Had In The Last 6 Months :

MUSCULO-SKELETAL
____ Low Back Pain
____ Shoulder Blade Pain
____ Neck Pain
____ Arm Pain
____ Joint Pain
____ Walking Problems
____ Jaw Pain
____ Headaches
____ Numbness
____ Dizziness
____ Fainting
____ Cold/Tingling Extremities

GASTROINTESTINAL
____ Excessive Thirst
____ Poor/ Excessive Appetite
____ Vomiting
____ Diarrhea
____ Constipation
____ Liver Trouble
____ Gall Bladder
____ Weight Trouble
____ Black Stool
____ Painful Urination
____ Bladder Trouble

C-V-R
____ Chest Pain
____ Shortness Breath
____ Blood Pressure
____ Irregular Rhythm
____ Heart Problems
____ Lung Problems
____ Ankle Swelling

MALE/FEMALE
_____ Menstrual Irregularity
_____ Breast Pain/Lumps
_____ Prostate /Sexual Dysfunction

ARE YOU PREGNANT ? _____ Yes _____ No

FAMILY HEALTH HISTORY (Many health problems are the result of hereditary factors)

Name	Relation	Health Problems

EXERCISE
□ None
□ Moderate
□ Daily
□Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

SMOKE
□ Never
□ Former Smoker
□ Current/every day smoker
□ Current some day smoker

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications
What medications are you currently taking? Include vitamins, herbs, minerals…
Please be as specific as possible

_____
_____
_____
_____
_____

Do you have allergies? □Food □Environmental □Medication
List Type of Allergy and Reaction

_____
_____

Assignment & Release

I understand and agree that health and accident Insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Tri-County Chiropractic 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 to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payments. If payment is not received from my Insurance Company within a reasonable amount of time, charges incurred are payable in full. Patients are also responsible for the remaining charges not covered by the insurance company. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs if required to collect my bill. I authorize payment of medical benefits to Tri-County Chiropractic for services performed. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I hereby authorize Tri-County Chiropractic its staff and physicians to treat my condition as deems necessary and appropriate. It is understood and agreed the amount paid to Tri-County Chiropractic, for X-Rays, is for examination only and the X-Ray negatives will remain the property of this office.

Patient's Signature : _____

Guardian or Parent : _____

Date : _____

BENNITT C. PATTERSON, P.A. d/b/a TRI-COUNTY CHIROPRACTIC
NOTICE OF PRIVACY AND INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and staff.

Our practice is required to abide by this notice. We have a right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in the office.

You may file a complaint about privacy violations by contacting our COMPLIANCE OFFICER.

Her name is C'Dell Stalvey (352) 493-1540.

The effective date of this Notice of Privacy and Information Practices is August 30, 2013.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY AND INFORMATION PRACTICES

I acknowledge that I was provided upon request a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Parent, Guardian or Patient's legal representative

_____ _____

Signature Date

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____