ID#: ____________________

Perry Chiropractic Health Center

Patient Information:

Name:____ Today's Date: ________/________/________

Address:__________________________________ City:_____________________ State:______ Zip: ___________

Home Phone:___________________ Work Phone:____________________ Mobile Phone:___________________

Email Address:____ Marital Status: ☐ Single ☐ Married

Social Security #:______________________________ Birth Date: _______/________/________ Age:________

Gender: ☐ Male ☐ Female ☐ Unspecified Race: ___________ Ethnicity: _______________

Employer:_____________________________________ Occupation:__________________________________

Number of children and ages: ____

Emergency contact name:__________________________ Relationship:____________ Phone #:______________

Have you ever seen a chiropractor before? ☐ Yes ☐ No If **yes**, for what? ________________________________

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

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Perry Chiropractic Health Center, or Dr. Brian Gillis, D.C for services rendered. 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:

Patient's Signature: ____ Date: _______________________________

Guardian's Signature Authorizing Care (if a minor): ____ Date: ____________

History of Complaint:

Please identify the condition(s) that brought you to this office: Primary:___________________________________

Secondary:_________________________ Third:__________________________ Fourth:________________________

When did the problem(s) begin?________________ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day

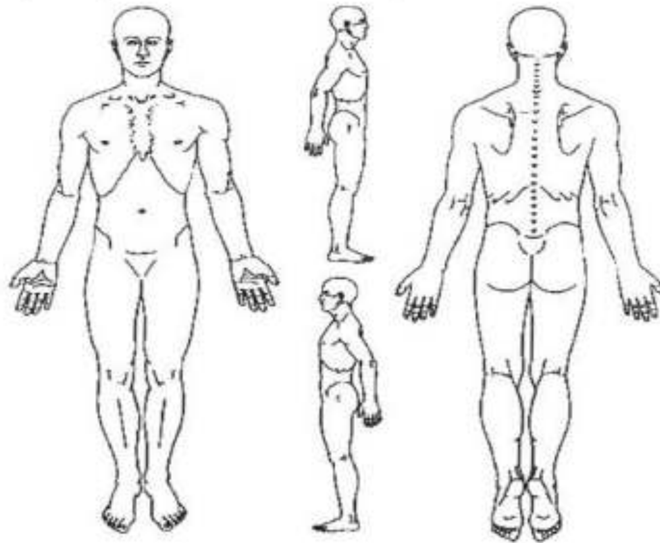
How long does it last? ☐ Constant **OR** ☐ On and off during the day **OR** ☐ Comes and goes throughout the week

How did the injury happen?____

Condition(s) ever been treated by anyone in t he past? ☐ Yes ☐ No If **yes**, when? _________ By whom?_______

PLEASE MARK the areas on the body diagram with the following letters to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling



Past Medical History:

Have you suffered with any of this problem or similar in the past? ☐Yes ☐No **If yes**, how many times? ______

When was the last episode? _________________________ How did the injury happen?_______________________

Other forms of treatment tried: ☐Yes ☐No **If yes**, what type of treatment? _____________________________

Who provided it? _______________________ How long ago? ___________ Results ☐Favorable ☐ Unfavorable

List any medications you are taking: ____

Are you allergic to any medications? ☐ Yes ☐ No **If yes**, please list:_______________________________________

List any surgeries you have had over the course of your life:

____

____

Family / Social History:

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No If yes, whom?

☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐Son(s) ☐Daughter(s)

Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes ____________________________

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcohol: Consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Review of Systems:

Please check all symptoms you have ever had, even if they do not seem related to your current problems:

___Headaches	___Ear Infections	___Kidney Problems	___Numb/Tingling	___Fibromyalgia
___Migraines	___Hearing Loss	___Menstrual Problems	___Jaw/TMJ Pain	___Arthritis
___Neck Pain	___Stroke	___Dizziness	___Asthma	___Bladder Problem
___Mid Back Pain	___Fatigue	___Infertility	___Elbow/Wrist Pain	___Shoulder Pain
___Low Back Pain	___Vertigo	___Seizures	___High blood pressure	___Foot Pain
___Allergies	___Gastric Reflux	___Heart Attack	___Anxiety	___Thyroid disorder
___Skin problems	___ADD/ADHD	___Disc Problems	___Knee Pain	___Hip/Leg Pain
___Depression	___Constipation	___Scoliosis	___Sciatic Pain	___Diabetes (1 or 2)

Informed Consent:

I have been advised that chiropractic care, like all other forms of health care, holds certain risks. These risks include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, strains and dislocations, and costovertebral strains and separation. Rare complications include but are not limited to stroke which occurs at a rate between one instance per one million to one per two million, have also been associated with chiropractic care.

Treatment objectives, as well as the risks associated with chiropractic adjustments and other procedures provided at Perry Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I consent to treatment that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_______________________________________ _____________________________________ ___________

Patient Name (print) Patient or authorized signature Date

Health Care Authorization Form

Patient's Name ____ Date of Birth: ____________________

The patient identified above authorizes **Perry Chiropractic Health Center** to use and/or disclose protected health information in accordance with the following:

☐ I give permission to **PCHC** to use my address, phone number, and clinical records to contact me by phone, text, or email with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, thank you cards, testimonials, marketing materials, information about treatment alternative, or other health related information.

☐ If **PCHC** contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

☐ I give **PCHC** permission to text me with appointment reminders and/or missed appointment details.

☐I give **PCHC** permission to treat me in an open therapy room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Financial Authorization

☐ I understand that estimated insurance coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.

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☐ I understand that I am responsible for payment on the day that services are rendered.

By signing this form, you are giving **PCHC** permission to use and disclose your protected health information in accordance with the directives listed above.

Patient signature: ____ Date: _________________

Female patients only: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the X-rays are taken at **PCHC**. Date of last menstrual cycle: _____/_____/_____

Signature: ____ Date: __________________