NEW PATIENT APPLICATION

Welcome to our practice! Please thoroughly complete all questions, thank you.

Name: _____ Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: M/W/D/S Date of Birth: ____/____/____ Age: _____

Emergency Contact Name/Relationship: _____

Emergency Contact Phone Number: _____

How did you hear about us? _____

Previous Chiropractor Name and Office: _____

Chiropractic techniques you've had success with: _____

When was your last visit to your Chiropractor? _____

General Practitioner Name and Office: _____

Employer/Occupation: _____ Employer's Address: _____

Spouse's Name and Employer/Occupation: _____

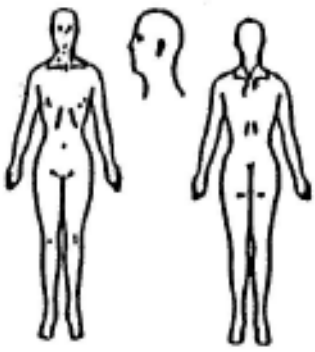
Children's Names and Age: _____

What are your hobbies and interests? _____

Health reasons for consulting our office?

1. _____
2. _____
3. _____
4. _____

Mark Areas of Health Concern:



Method of payment for first visit:

_____ Cash _____ Check ____ Credit Card _____ Heath Savings Account

Have you had similar health problems before? ____ Yes ____ NO

For how long? _____

Do you have family history with the same problem? _____

Is this a result of an auto or work injury? ____ Yes ____ NO

If so, please explain: _____

If this is a work injury, is there a panel chiropractor that your company's Workman's Compensation Insurance requires you to see in the first 90 days? If so, please list their name:

_____

Please list any other doctors that have treated this problem:_____

_____

Have you had any surgeries? If so, please list them: _____

Medications you currently take: _____

Is there any chance you are pregnant? ____ Yes ____ NO

What have you heard about Chiropractic Care?

_____

Do you know what a subluxation is? If yes, please describe:

_____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer? ____ Yes ____ NO

If so, what type? _____

The above information is true and accurate to the best of my knowledge.

Patient of Guardian Signature: _____

Date: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____

Print Name Signature Date

X-Ray Release

I understand that according to state law the original X-Rays taken of me today are required to be maintained on these premises for seven (7) years. I further understand that should I require copies of these films for another doctor's use that a copying fee of $5.00 per film or $30.00 per set will apply. All requests for copies require three (3) days' notice.

TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AND THEREFORE ALLOW X-RAYS TO BE TAKEN.

☐ Does not apply

_____

Signature Date

Patient or Authorized Person's Signature

I authorize release of any medical information necessary to process this claim and request payment of insurance or medical benefits to be paid directly to Clairpointe Family Chiropractic.

_____

Signature Date

Records Release

To _____, I hereby authorize you to release to _____

_____ any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

_____

Signature Date

Consent of Treatment of Minor Child

I hereby authorize Dr. Shoemaker and whomever he may designate as his assistant to administer chiropractic care as he deems necessary to my _____.
(indicate relationship of child)

_____

Name City and State where this was signed

_____

Signature Date