



NEW PATIENT APPLICATION

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

Name: _____

Address: _____

E-Mail: _____

Cell Phone: _____ Home 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? _____

When was your last visit to your Chiropractor? _____

Occupation: _____

What are your hobbies and interests? _____

Health reasons for consulting our office?

1. _____

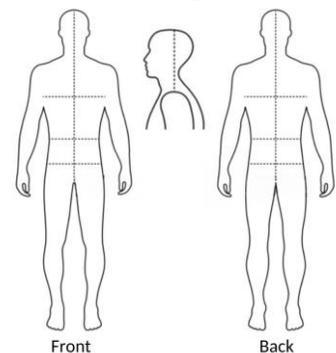
2. _____

3. _____

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

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

Mark areas of health concerns
on the diagram:



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

Patient or 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 healthcare information:

- We may have to disclose your health information to another healthcare 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 changes 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

By signing this release, I am allowing Clairpointe Family Chiropractic to move forward with x-rays. 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. All requests for copies require three (3) days' notice.

Signature

Date

I AM PREGNANT AND THEREFORE DO NOT ALLOW X-RAYS TO BE TAKEN.

Yes Does Not Apply

Insurance

I authorize the release of any medical information necessary to process this claim and request that insurance or medical benefits 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 the relationship to the child)

Name

City and State where this was signed

Signature

Date