

# ADVANTAGE SPINE & DISC

## Confidential Patient Information

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # (\_\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_

Home Email \_\_\_\_\_ Work Email \_\_\_\_\_

Contact Method (check one)  Home Phone  Cell Phone  Work Phone

Which email address would you like us to use to communicate with you?  Home  Work

D.O.B. (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Widowed  Other Spouse's Name \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_ Address \_\_\_\_\_

Employment Status (check one)  Employed  FT Student  PT Student  Other  Retired  Self Employed

Spouse's Employer \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ Spouse SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Multi-Racial (check one)  Yes  No  Unknown Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino

Race (check one)

- |                                   |   |                                      |  |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White    | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic    | <input type="checkbox"/> American Indian/Alaskan Native          |
| <input type="checkbox"/> Asian    | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Chinese     | <input type="checkbox"/> Filipino                                |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan   | <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify                 |

Preferred Language (check one)

- |                                  |                                     |   |  |  |                                 |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish    | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese       | <input type="checkbox"/> French                  | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian                | <input type="checkbox"/> Korean        | <input type="checkbox"/> Russian                 | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic  | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese               | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek                   | <input type="checkbox"/> Hindi  |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu       | <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Armenian      | <input type="checkbox"/> I choose not to specify |                                 |

Verification Question (Choose only one question by checking the question, then give the answer to the question.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> What is the name of your favorite pet? | <input type="checkbox"/> In what city were you born?  | <input type="checkbox"/> What high school did you attend? |
| <input type="checkbox"/> What is your mother's maiden name?     | <input type="checkbox"/> What is your favorite movie? | <input type="checkbox"/> On what street did you grow up?  |
| <input type="checkbox"/> What was the make of your first car?   | <input type="checkbox"/> When is your anniversary?    | <input type="checkbox"/> What is your favorite color?     |

Verification Answer to the chosen question:\*\* \_\_\_\_\_

\*\*Must be 6 characters or longer

**How did you find out about our office/who referred you to us?** \_\_\_\_\_

- Friend/Family  Doctor  TV  Internet  Sign  Phonebook  Home Mailer  Newspaper (please give ad to front desk)

Is your visit due to an accident?  No  Yes (if yes, please see receptionist for an injury report.)

## Your Present Complaint \_\_\_\_\_

BRIEFLY DESCRIBE YOUR SYMPTOMS \_\_\_\_\_

List other doctor(s) seen for this condition \_\_\_\_\_

**Medical History** (if any of the following are relevant to your medical history, please check the accompanying box)

- |                                    |  |  |  |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Concussion          | <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Numbness        |
| List: _____                        | <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever   |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Sinus Trouble   |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Tuberculosis    |

Describe any operations you've had (and dates): \_\_\_\_\_

Have you been treated by a physician for any health condition in the last year?  No  Yes

Describe condition: \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Current medications, including dosage if know. If there are no medications check here:

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

List any known allergies you have had to any medications. If no allergies are known, check here:

- |          |          |
|----------|----------|
| 1) _____ | 2) _____ |
|----------|----------|

Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe \_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II

If yes to Diabetes, was your blood lab-work test hemoglobin A1c > 9.0%?  Yes  No  Not Sure

If yes, other comments regarding Diabetes: \_\_\_\_\_

Do you currently use tobacco of any kind?  Yes  Former smoker/user  Never been a smoker/user

If yes, how often do you smoke/use:  Current every day smoker  Current sometimes smoker

If yes, what is your level of interest in quitting smoking: no interest  0  1  2  3  4  5  6  7  8  9  10 very interested

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No

Have you had any other X-ray or CT scan or MRI in the past year?  Yes  No if yes, describe \_\_\_\_\_

Are you pregnant?  Yes  No

Date of last menstrual period \_\_\_\_\_

**Do you have insurance?**  Yes  No

**Company** \_\_\_\_\_

**Policy Number** \_\_\_\_\_

**Group Number** \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Advantage Walk-In Chiropractic extends credit to me, and I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I understand that if my account is 60 days past due an \$5 late fee will be assessed per billing cycle and any accounts 120 days past due will be forwarded to our collections department and will be subject to collection-processing fees. If my check is dishonored I understand that a \$25 processing fee will be assessed to my account. I hereby authorize the doctors at Advantage Walk-In Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

**Patient's (Parent or Guardian's) Signature** \_\_\_\_\_

**Advantage Spine & Disc -- Jamie M. Ricks, D.C.**

**Personal Medical Information Consent Form**

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive payment and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions. But if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Restrictions: