CHIROPRACTIC & SPORTS CLINIC

MEDICAL RECORDS POLICY AND PROCEDURES

As a patient of the Chiropractic and Sports Clinic, you are entitled, at any time during regular business hours, to request your medical records or diagnostic films from our office. The following are the policies/procedures aimed at making the process of completing your request as quickly and efficiently as possible:

- Notify the Custodian of Records of your request. Your records will be copied at our earliest convenience.
- Requests by third parties (attorneys, insurance carrier, doctor's office, etc.) must be made directly to the Custodian of Records in writing and accompanied by a signed release from you.

We appreciate your patience during the process of completing your request.

CONTACT INFORMATION

Home Number:_____

Work Number:_____

Cell Number:_____

Email Address:_____

A detailed message may be left at this number:	HOME	WORK	CELL
A message may be left with only name and call back number:	HOME	WORK	CELL
Please do not leave a message at this number:	HOME	WORK	CELL

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Policies, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature Date

_____

Printed Name

I wish to object to the following in the "Notice of Privacy Practices"

_____

_____

_____

BENEFITS ASSIGNED

I hereby authorize the insurance company to pay directly to _____ all benefits to which I am entitled under the terms of this policy.

_____
Name

_____
Date

I hereby authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment above.

_____
Name

_____
Date

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the _____will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to the _____ will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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.

Patient's Signature:_____ Date:_____

Guardian or Spouse's Signature:_____ Date:_____

CONFIDENTIAL PATIENT INFORMATION

Date:_____

Name_____ Phone (H)_____ (C)_____

Address_____ City_____ State_____ Zip_____

Age_____ Birthdate_____ Marital Status M S W D Children_____

Occupation_____ SS#_____ Employer_____

Address_____ Office Phone_____

Driver's License Number_____

Name of Wife or Husband_____ SS#_____

Employer_____ Office Phone_____

PATIENT'S Nearest Relative_____

Address_____

Referred by:_____

CURRENT HEALTH CONDITIONS

Purpose of this appointment:_____

_____

Other doctors seen for this condition:_____

When did this condition begin:_____

If disabled from work please give dates:_____

o Job Related o Auto Related

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other:_____

_____

PAST HEALTH HISTORY

Please check or describe:

Major Surgery/Operations: ☐ Apendectomy ☐ Tonsillectomy ☐ Hernia ☐ Gall Bladder ☐ Hernia

☐ Broken Bones: _____ ☐ Other:_____

Major Accidents or Falls:_____

_____

Hospitalization (Other Than Above):_____

_____

Previous Chiropractic Care: ☐ None

☐ Doctor's Name & Approx. Date of Last Visit:_____

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain:_____

Happy with your current weight? Would you be interested in any of our weight loss programs? ☐ Yes ☐ No

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Appendicitis
☐ Scarlet Fever
☐ Diphtheria
☐ Typhoid Fever
☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Malaria
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Goiter
☐ Influenza
☐ Pleurisy
☐ Alcoholism
☐ Venereal Infection
☐ Arthritis
☐ Epilepsy
☐ Mental Disorder
☐ Lumbago
☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Bladder Trouble
☐ Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Cold/Tingling Extremities

GENERAL CODE

☐ Allergies
☐ Fever
☐ Headaches
☐ Sore Throat

GASTRO-INTESTINAL CODE

☐ Poor/Excessive Appetite
☐ Ecxcessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Trouble
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE

☐ Painful/Excessive Urination
☐ Discolored Urine

C-V-R CODE

☐ Chest Pain
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle swelling

EENT CODE

☐ Vision Problems
☐ Dental Problems
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

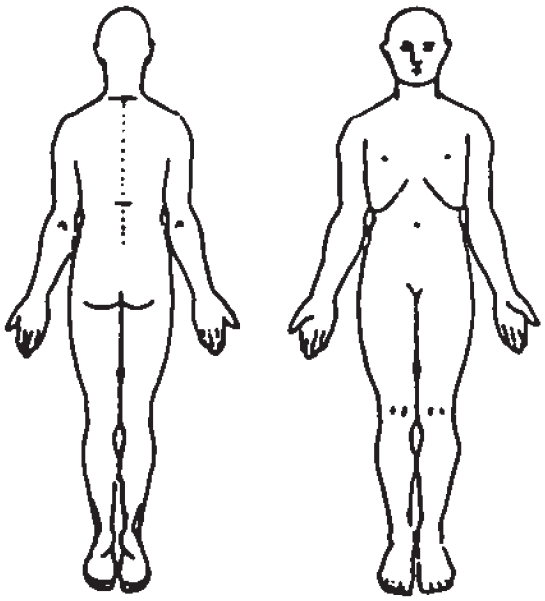
MALE/FEMALE CODE

☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain/Infections
☐ Breast Pain/Lumps
☐ Prostate/Sexual Dysfunction
☐ Genital Herpes

FEMALES ONLY:

When was your last period?_____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe



Please outline on the diagram the area of your discomfort.