New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name ______________________ Date ________ Email ______________________

Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address ______________________ City __________ State _____ Zip _______

Telephone (work) __________ (home) __________ Referred By ______________

Age _____ Birth date __________ Social Security # __________ Number of children _____

Occupation ______________________ Employer ______________________

Marital Status __________ Spouse's name __________ Spouse's Occupation __________

Spouse's employer ______________ Spouse's health status ______________

Emergency contact ______________________ Phone ______________

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

Please describe ____

____

Date of injury __________ Date symptoms appeared __________

Have you ever had same condition? ☐ No ☐ Yes If yes, when? ______________

List other practioners seen for this injury/condition ______________

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe ____

Insurance Information

Name of party responsible for payment ______________ Phone ______________

Do you have health insurance? ☐ No ☐ Yes Name of company ______________

** If an auto accident please provide:*

Insurance company name ______________ Contact person ______________

Phone ______________ Claim # ______________

Billing Address

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ______________________________ Date ______________

Spouse's or guardian's signature ______________________ Date ______________

Medical History

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

If yes, please describe ______________________

Date of last physical exam __________ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? ______________________

What medications are you taking and for what conditions (Please list dosage and amounts, etc). __________

____

____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

____

____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had Sprains/Strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

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Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:_______________________ **Last Name:**_______________________

Email address: ________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
Write on back page if need more space	

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ______________________________________ Date:______________

Notice of Privacy for:
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business assoc. sending written assurances for your privacy have been attained.
- Emergency situations. Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Krissy and can be reached at FCC regarding privacy issues, to render a complaint to our privacy officer.
- Inspect, copy and amend your protected health information and amend it as allowed by law.

This office reserves the right to change the terms on this notice to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.
I acknowledge that I have received and reviewed this notice with full understanding.

____

Name of patient | Signature or Legal Representative | Date

One Time Authorization

I hereby authorize FCC to furnish information to insurance carriers concerning my illness & treatments and I assign to same all payments for medical services rendered to me. I understand that my insurance will be billed as a courtesy and I agree to be financially responsible for any balance due to FCC. I also authorize FCC to perform any treatment which is considered medically necessary by the Dr. A photocopy of the authorization and assignment shall be considered as valid as the original.

____

Name of patient | Signature or Legal Representative | Date

Traci A. Collier, D.C.
DOCTOR OF CHIROPRACTIC

Family Chiropractic Clinic
Of Saginaw, PLC

70 N. FROST DRIVE
SAGINAW, MI 48638

(989) 792-1718
FAX (989) 792-1814

Chiropractic Treatment • Massage Therapy

CANCELLATION POLICY

If you are unable to keep your scheduled appointment , please give 24-hour notice. There will be a $25.00 charge for every missed or no-show appointment.

Thank You for your cooperation.

I acknowledge and understand the above statements.

Name ______________________________

Date ____________________