Confidential Patient Information

Patient name: _____ Gender: M F Marital Status: M S D W under 18

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Employer: _____

Person responsible for account (name & address if different than patient): _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes No

Primary insurance: _____ Name of policy holder: _____

Policy holder DOB: _____ Policy holder relationship to patient: self spouse parent

Secondary insurance: _____ Name of policy holder: _____

Policy holder DOB: _____ Policy holder relationship to patient: self spouse parent

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Minster Chiropractic Center LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. I have read and fully understand this agreement.

_____ _____

Signature of insured / guardian Date

Terms of Acceptance

Consent to Professional Treatment:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a doctor at **Minster Chiropractic Center**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding the chiropractic treatment, will be explained to me upon my request.

Initial _____

If the patient is a minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above consent to professional treatment and hereby grant permission for my child to receive chiropractic care.

Initial _____

Financial Policy (on separate page)

I have read and understand the financial policy of Minster Chiropractic Center and agree to the terms. I may request a copy at any time.

Initial _____

Notice of Privacy Practices (on separate page)

I have read and understand the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Minster Chiropractic Center has the right to change its Notice of Privacy Practices and that I may contact them at any time to obtain a current copy.

Initial _____

Acknowledgement

I have read and fully understand the above statements. I agree to the items which I have initialed above.

Print Name: _____

Signature: _____ Date: _____
(parent or legal guardian if under 18)

For office use only: We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

Patient Information Update

Name: _____ Date: _____

Family Physician: _____ Date of last physical: _____

Have you ever been to a chiropractor? Yes No To an acupuncturist? Yes No

Do you have a history of cancer? Yes No *If yes, please list:* _____

Do you have any implanted electrical devices (pacemaker): Yes No

Are you currently pregnant? Yes No *If yes, how many months?* _____

Have you had any X-Rays / MRI's / CT's taken in the last 5 years? Yes No
If yes, please list area of body and hospital AND clinic where images were taken

1) _____

2) _____

Please list ALL surgeries, *including type of surgery and year it was performed*:

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

Please list any allergies or sensitivities (*including* medications, environment, food):

_____

_____

Are you currently taking any supplements? Yes No *If yes, please list:*

_____

_____

Are you currently taking any prescription medications? Yes No *If yes, please list:*

a. _____
b. _____
c. _____
d. _____
e. _____

**if you have a written list for us to copy, you do not have to re-write them here.*

Chief Complaint

Name: _____ DOB: _____ Date: _____

What caused you to seek care in our clinic today?

_____

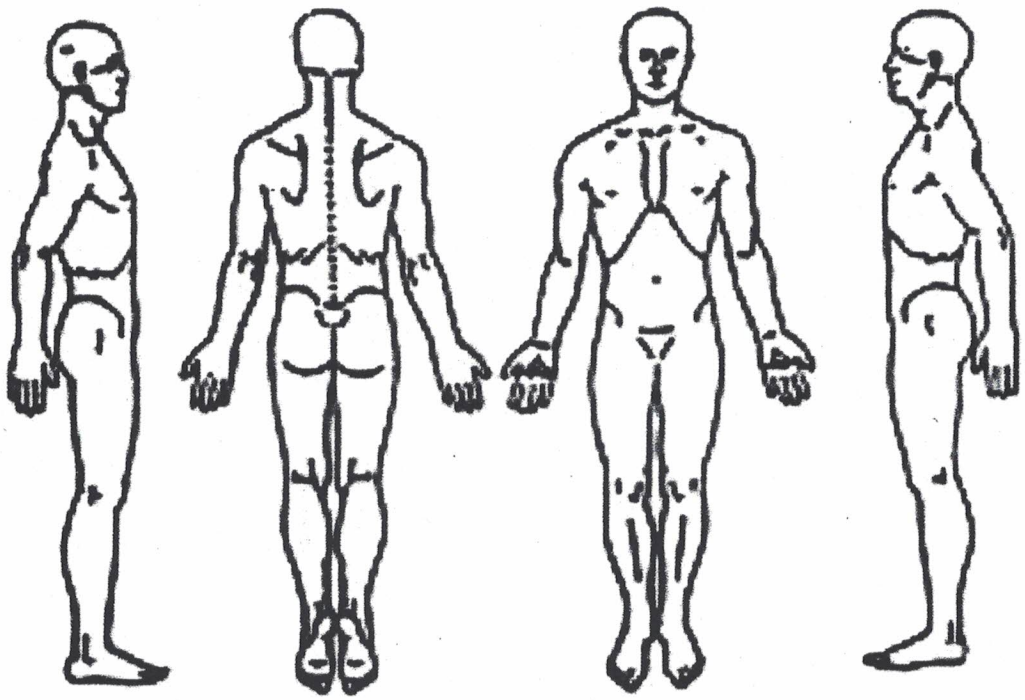
What would you like to be able to do that you cannot currently due to pain or disability?

_____

Please rate your primary pain on a scale from 0 (no pain) – 10 (worst pain imaginable): _____

Mark the area(s) where you experience pain or other abnormal sensation on the diagrams below:

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
========	**********	XXXXXXXXX	OOOOOOOO	//////////



To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. While this office will do its best to keep the most updated information on file, I understand that it is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature: _____

Past Medical History

Please indicate if you have had the condition in the *past,* or if you *presently* have the condition:

past	*present*	General
		Anxiety
		Depression
		Dizziness
		Fatigue
		Fever or chills
		Weight loss or gain
		Musculoskeletal
		Degenerative arthritis
		Neck and upper back pain
		Low back pain
		Other joint pain
		Numbness or tingling
		Muscle weakness
		Osteoporosis
		Rheumatoid arthritis
		Scoliosis
		Gastrointestinal
		Abdominal pain
		Colitis / Crohn's
		Constipation
		Diarrhea
		GERD or heartburn
		Irritable Bowel Syndrome
		Liver / Gallbladder problems
		Nausea
		Ulcer
		Neurological
		Brain fog
		Headache or migraine
		Memory loss
		Multiple sclerosis
		Seizure
		Cardiovascular
		High blood pressure
		Irregular pulse
		Stroke
		Swelling at ankles
		Varicose veins
		Respiratory
		Asthma
		Chronic cough
		COPD

past	*present*	Ear, Eye, Nose, Throat
		Earache / Ear infection
		Impaired hearing
		Ringing in the ears
		Sinus infection
		Vision problems
		Endocrine
		Diabetes (type 1)
		Diabetes (type 2)
		Hyperthyroidism
		Hypothyroidism
		Skin
		Acne
		Eczema
		Itching / Rash
		Genitourinary
		Bedwetting
		Bladder infection
		Kidney infection or stones
		Blood
		Anemia
		Bleeding disorder
		Male specific
		Fertility trouble
		Prostate disease
		Female specific
		Fertility trouble
		Hot flashes
		Irregular or painful periods
		Menopause
		PCOS
		Recurrent miscarriage
		FAMILY HISTORY
		Autoimmune disease
		Cancer
		Diabetes
		Heart attack
		Neurological disease
		Osteoporosis
		Stroke

Do you have any other health issues or concerns that you would like to share?

_____

_____

_____ _____

Patient's signature ***Date***