

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____

Email: _____ Gender: M / F Marital Status: Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: _____ Age: _____

Preferred patient reminders: email / text Occupation: _____ Employer: _____

Who may we thank for referring you to our office? _____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer Preferred Language: _____

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

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Name of Previous Chiropractor: _____

Home: _____ Mobile: _____ Date of Last Chiropractic Adjustment: _____

Relationship: Child / Parent / Spouse / Other: _____ Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION -- *Please allow our staff to photocopy your insurance card.*

Insurance Self Pay (Cash) Personal Injury/Auto Other (please explain) _____

PRIMARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

**Many of the following conditions respond to Chiropractic treatment.
Are you currently experiencing any of these symptoms? (check all that apply)**

General: (constitutional)

- Recent Weight Change
- Fever
- Fatigue
- None in this Category*

Musculoskeletal:

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems _____
- Leg Problems _____
- Painful Joints
- Stiff/Swollen Joints
- Sore/Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones
- Other: _____
- None in this Category*

Neurological:

- Numbness or Tingling Sensations
- Loss of Feeling
- Dizziness or Light Headed
- Frequent or Recurrent Headaches
- Convulsions or Seizures
- Tremors
- Stroke
- Have you ever had a head injury?
- Ever been in an auto accident?
- Other: _____
- None in this Category*

Mind/Stress:

- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: _____
- None in this Category*

Genitourinary:

- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in Force/Strain w/Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: _____
- None in this Category*

Gastrointestinal:

- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: _____
- None in this Category*

Cardiovascular & Heart:

- Chest Pains
- Rapid or Heartbeat Changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- Other: _____
- None in this Category*

Respiratory:

- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other: _____
- None in this Category*

Eyes and Vision:

- Wear contacts/glasses
- Blurred or Double Vision
- Glaucoma
- Eye Disease or Injury
- Other: _____
- None in this Category*

Ears, Nose and Throat:

- Bleeding gums/Mouth sores
- Bad Breath or Bad Taste
- Dental Problems
- Swollen Throat or Voice Change
- Swollen Glands in Neck
- Ringing in the Ears
- Ear-Ache/Ringing/Drainage
- Sinus/Allergy Problems
- Nose Bleeds
- Hearing Loss
- Other: _____
- None in this Category*

Endocrine, Hematologic, and Lymphatic:

- Thyroid problems
- Diabetes
- Excessive Thirst or Urination
- Cold Extremities
- Heat or cold Intolerance
- Change in hat or glove size
- Dry Skin
- Glandular or Hormone Problem
- Swollen Glands
- Anemia
- Easily Bruise or Bleed
- Phlebitis
- Transfusion
- Immune System Disorder
- Other: _____
- None in this Category*

Skin and Breasts:

- Rash or Itching
- Change in Skin Color
- Change in Hair or Nails
- Non-healing Sores
- Change of Appearance of a Mole
- Breast Pain
- Breast Lump
- Breast Discharge
- Other: _____
- None in this Category*

Women Only:

Are you pregnant?

- Yes-Due Date _____
- No-Last Menstrual Period _____
- Infertility
- Painful or Irregular Periods
- Vaginal Discharge
- Other: _____
- None in this Category*

Pregnancies with Outcome & Date

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. 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 or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Print Name: _____

Pregnancy Warning & Consent to X-ray

Patient Name: _____ Date: ___/___/___

I understand that I may injure my fetus if I am pregnant and have X-rays taken that expose radiation to my lower torso.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray exams.

	Yes	No	Don't Know
I am pregnant	___	___	___
I could be pregnant	___	___	___
I am late with my menstrual period	___	___	___
I am taking oral contraceptives	___	___	___
I have an IUD	___	___	___
I have had a tubule ligation	___	___	___
I have had a hysterectomy	___	___	___
I have irregular menstrual periods	___	___	___

My last menstrual period began on: ___/___/___

Fully understanding the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed.

Signature

Witness Signature

Date: ___/___/___

HIPAA/Patient Health Information Consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operation, the chiropractic physician has the right to refuse to give care.
8. We have an open front desk and all of our financial arrangements are discussed at the front counter. If you feel that you need a more private place to discuss your financial arrangements we can always move to a private room. Please notify the office staff or doctor if any arrangements need to be made.
9. When you refer a patient to our office you will be recognized by first name, last initial on our Thank You Board, Article of the Month, and Thank you/referral letters.

INFORMED CONSENT AND CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may design as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employee of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I also have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby direct all insures and other persons responsible for the this PATIENT'S health care cost to make all payments for health care services rendered by Shelton Chiropractic directly to Global Chiropractic Plano/Frisco. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account upon receipt. I certify this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized. I also understand if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I also agree, any and all checks sent to me directly from my insurance company for services rendered at this chiropractic office, will be sent to 7924 Preston Rd Suite 300, Plano, TX 75024 and will be credited to my account. Furthermore, if I fail to return said insurance payments, I agree I will be held liable for any attorney fees incurred by Global Chiropractic Plano/Frisco to recover said payments.

Signature of Patient/Guardian

Date

Texas State law requires that we inform you in writing of your charges at each visit. Please indicate below your choice of receiving a paper receipt detailing the charges for each visit.

_____**Yes**, I would like a printed Appointment Receipt at each visit. By checking this box, I understand that it is my responsibility to request this at check out.

_____**No**, I do not wish to receive any of my printed Appointment Receipts. I understand that I may request any Appointment Receipt for any point in the future
