PREMIER CHIROPRACTIC & SPORTS INJURY CENTER

Patient Information

Patient Legal Name (First, MI, Last):_____ Preferred name:_____
Mailing Address: _____Apt #_____Sex: M F
City:_____State:_____Zip_____Date of Birth: _____
Social Security #:_____ Marital Status: S M D W Spouse's Name: _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #:_____ Contact Preference: Home Cell Work
E-mail Address:_____
Occupation: _____ Employer: _____
Employer Address: _____
Emergency Contact: _____Relation:_____Phone #:_____
Whom may we thank for referring you to our office?:_____

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information

Are you the policy holder? Yes No If not, who is the policy holder?: Spouse Parent Employer Other

Policy Holder's Name: _____
Insurance Company:_____ Policy ID #:_____
Policy Holder's DOB: _____ Policy Holder's Employer:_____

Do you have secondary insurance coverage? Yes No If yes, please complete the following:

Policy Holder's Name: _____
Insurance Company:_____ Policy ID #:_____
Policy Holder's DOB: _____ Policy Holder's Employer:_____

Assignment and Release

I understand and agree that health and accident insurance policies are an agreement 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 doctor's office will be credited to my account upon receipt. 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.** I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Signature:_____ Date:_____
(Patient/Legal Guardian of Minor)

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate 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; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature:_____ Date:_____
(Patient/Legal Guardian of Minor)

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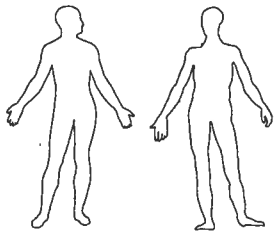
Reason for today's visit: ___ Emergency ___ New Injury ___ Old Injury ___ Chronic Pain ___ Wellness
Are you in Pain? **Y N** Rate your pain on a scale of 0-10 (0-no pain, 10-worst pain imaginable) _____
Did your injury occur during: ___ Work ___ Sports/play ___ Auto Accident ___ Routine Activity
When did your condition/accident occur? _____
Where did your injury occur?_____
Please explain what happened_____
Is your condition getting worse? **Y N** ___ Constant ___ Comes and goes
Is your condition interfering with your: ___ Work ___Sleep ___Daily routine?___ If so, how:_____

Using the body charts, please circle all affected areas.



Front Back

Has this or something similar happened in the past? **Y N**
Explain: _____
_____
Have you been treated by a medical physician for this condition? **Y N** If so, where? _____
_____
Have you ever been treated by a Chiropractor? **Y N**
Clinic or Dr's Name: _____
Clinic Phone #: _____

Health History

Are you taking any of the following medications? ___ Pain killers (including aspirin) __ Muscle Relaxers __ Blood Thinners __ Tranquilizers __ Insulin __ Other(s)_____

Do you have or have had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack/Stroke
Y N Artificial Valves
Y N Shingles
Y N High/Low Blood Pressure
Y N Ulcer/Colitis
Y N Difficulty Breathing
Y N Heart Surg./Pacemaker
Y N Alcohol/Drug Abuse
Y N Cancer
Y N Psychiatric Care
Y N Fainting/Seizures/Epilepsy
Y N Chemotherapy
Y N Heart Murmur
Y N Venereal Disease
Y N Frequent Neck Pain
Y N Rheumatic Fever
Y N Sinus Problems
Y N Lower Back Problems
Y N Congenital Heart Defect
Y N Hepatitis
Y N Glaucoma
Y N Severe/Frequent Headaches
Y N Emphysema/Asthma
Y N Artificial Bones/Joints/Implants
Y N Mitral Valve Prolapse
Y N HIV+/AIDS/ARC
Y N Anemia/Diabetes
Y N Kidney Problems
Y N Tuberculosis
Y N Rheumatoid Arthritis
Y N Osteoarthritis
Y N Diabetes Type I or Type II

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:
_____
List any past serious accidents with dates:
_____
Please list anything that you may be allergic to: **Food** **Environment** **Medications**
_____
Family Health History:
_____
Do you take Supplements or Vitamins? **Y N** What?
_____
Do you exercise? **Y N**__ hours per week
Do you smoke? __Never __Former Smoker __Current/Every Day Smoker __Current Infrequent Smoker
Are you wearing: ___ Shoe lifts ___ Inner soles ___ Arch supports

For women:

Are you taking Birth Control? **Y N** Are you nursing? **Y N** Are you pregnant? **Y N** If so, how many weeks?_____

- We invite you discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Patient Name:_____Signature of Patient/Legal Guardian:_____Date_____

PREMIER CHIROPRACTIC
& SPORTS INJURY CENTER

HIPPA Release

In the course of your care as a patient at Premier Chiropractic & Sports Injury Center we may use or disclose personal and health related information about you in the following ways:

* Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.

* Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMP, a PPO, or your employer (if they are or may be responsible for the payment of your services).

* Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

* Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances: If we are providing health care services to you based on the orders of another health care provider; in an emergency; if we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so; if there are substantial barriers to communicating with you; if we are ordered by the courts or another appropriate agency.

* You have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

* We are required by state and federal law to maintain the privacy of the patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

* We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this notice.

* If you have a complaint regarding our privacy notice or would like further information about our privacy policies and practices, please contact Dr. Brian E. Larson.

This notice is effective as of August 1, 2009. This notice will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Print Patient Name **Signature of Patient/Legal Guardian** **Date**

Due to changes in health care, it is required by law to obtain the following information on patients in our office:

Language: English Spanish Native American Russian Other(specify)_____
Race: White Alaska Native Hispanic/Latino Decline to Answer Other(specify)_____
Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to Answer