CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.

If you need help, please ask the receptionist. PLEASE PRINT.

Date: _____

Name: _____ Cell Phone: _____ Home Phone: _____

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

Age: _____ Birth Date: _____ Marital Status: M S W D # of Children _____

E-mail Address: _____Work Phone: _____ Your SS#: _____

Your Employer: _____ Occupation: _____ Years on Job: _____

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

Spouse or Parent's Name: _____Birth Date: _____Phone_____

Emergency Contact: _____ Phone: _____Relation:_____ Whom May We Thank

For Referring You to Us? _____

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company _____

<u>* Please Present Drivers License and Insurance Card At Front Desk *</u>

Main Complaint: _____

When Did It Start? _____What were you doing at the time?_____

What Activity Bothers It The Most? _____

When Is It At Its Best? _____ When Is It At Its Worst? _____

Rate the pain: (0 is pain free – 10 is unbearable pain): 1 2 3 4 5 6 7 8 9 10

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐Work/Job ☐At Home ☐ Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. 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's Signature (For Minors): _____ ***Date:*** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

HEALTH HISTORY

Name: _____ Date: _____

Name Of Local Primary Physician: _____ May We Contact Them? Yes ☐ No ☐

Other Type Of Physician Or Therapist? _____

Have you seen a Chiropractor before? _____ Positive Experience? _____

Previous Surgeries And Their Dates: _____

_____

List All Medications You Are Currently Taking: _____

_____

List Any Traumas And Their Dates: _____

_____

What Supplements Do You Take? _____

What Kind Of Exercise Do You Do? _____

Please Check The Conditions You Have Or Have Had:

( ) Anemia	( ) AIDS/HIV	( ) Multiple sclerosis	( ) Osteoporosis	( ) Diabetes ( ) 1 ( ) 2 ( ) Gestational
( ) Polio	( ) Tuberculosis	( ) Parkinson's disease	( ) Fibromyalgia	( ) Previous Head or Neck Injury
( ) Hernia	( ) Lyme Ds.	( ) Thyroid Dysfunction	( ) Spinal Stenosis	( ) Amalgam / Silver Fillings
( ) Stroke	( ) Epilepsy	( ) High Blood Pressure	( ) Herniated Disc	( ) Heavy Metal Poisoning
( ) Cancer	( ) Fractures	( ) Kidney Dysfunction	( ) Liver Dysfunction	( ) Arthritis: Type_____

Please Check All Present Symptoms:

( ) Headaches	( ) Upper Back Pain	( ) Irritability
( ) Migraine Headaches	( ) Pain Between Shoulder Blades	( ) Excessive Mood Swings
( ) Dizziness / Vertigo	( ) Trouble Raising Shoulder (Bursitis, Neuritis)	( ) Impotence / Sexual Dysfunction
( ) Ringing In Ears	( ) Numbness / Tingling in Arms or Hands	( ) Nervousness
( ) Allergies	( ) Shooting Pain in Arms or Hands	( ) Depression
( ) Sinusitis	( ) Tennis Elbow or Tendonitis	( ) Panic Attacks
( ) Frequent Colds	( ) Carpel Tunnel Syndrome	( ) Lower Back Pain
( ) Loss Of Smell	( ) Decreased Grip Strength	( ) Knee Pain
( ) Trigeminal Neuralgia	( ) Shoulder Pain	( ) Pain Down Leg / Sciatica
( ) Loss of Taste	( ) Irregular/ Rapid Heart Beat	( ) Pain In Buttocks
( ) Nose Bleeds	( ) Breathing Difficulty / Pain with Breathing	( ) Pain In Hip
( ) Muscle Weakness	( ) Asthma / Shortness of Breath	( ) Outer Leg Pain
( ) TMJ Dysfunction	( ) Generally Feel Run-Down	( ) Difficulty Walking
( ) Facial Pain	( ) Bloating / Gas	( ) Loss of coordination
( ) Phantom Tooth Pain	( ) Chronic Infections	( ) Shooting Pain in Legs or Feet
( ) Throat / Gland Swelling	( ) Chronic Fatigue	( ) Numbness / Tingling in Legs or Feet
( ) Limited Neck Movement	( ) Abdominal Pain	Rest: ( ) Sufficient or ( ) Insufficient
( ) Neck Pain	( ) Acid Reflux / Indigestion / Heart Burn	( ) Smoking: ___ Packs Per Week
( ) Pop and/or Grinding In Neck	( ) Diarrhea/ Constipation	( ) Alcohol Use

Women Only:

( ) Pregnant	( ) Painful Periods	( ) Lumps In Breast	# Of Pregnancies _____
( ) Nursing	( ) Irregular Periods	( ) Taking Birth Control Pills	# Of Deliveries _____

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. George Berry may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Notice of Privacy for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Berry reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Berry.

With my consent, Dr. Berry may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Dr. Berry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Dr. Berry's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Dr. Berry may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests. I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-ray.

_____ _____

Patient Signature Date

_____ _____

Witness Date

FEMALES ONLY:

I understand that x-rays may be needed at some point and that by signature on this form, I do herby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_____ _____

Patient Signature Date

_____ _____

Witness Date