

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

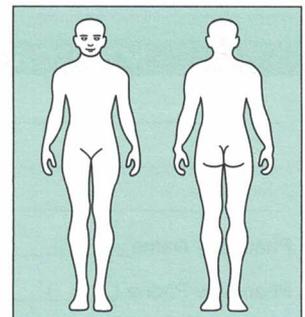
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

_____ _____ _____ Pharmacy Name _____ Pharmacy Phone (____) _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
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# Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

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

Smoking Start Date (Optional): \_\_\_\_\_

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		X		

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

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

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

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: \_\_\_\_\_

<b>For office use only</b>
Height: _____ Weight: _____ Blood Pressure: _____ / _____

**Financial Obligation / Assignment of Benefits**

It is your responsibility to inform the front desk of any and all updates to your insurance plan as well as your personal information. Failure to do so could result in charges becoming patient responsibility. I assign and authorize payments to Total Spine and Rehab, also known as TSR.

It is your responsibility to understand your insurance plan. Please make sure to contact your insurance provider to determine if TSR is in network and covered under your insurance plan. It is your responsibility to know what your deductible, copay, percentages, and other related expenses for treatment are. Be aware that our office has different types of providers. It is your responsibility to know if services related to treatment for Chiropractic, Physical Therapy, and Physical Therapy Assistant are covered under your insurance policy.

Our fees are considered usual, customary and reasonable by most companies.

You are responsible for the payment of charges for the health care we provide. Unless your health insurance company, HMO, or Medicare agreement with Total Spine and Rehab prohibits it, payment is due at the time of visit. Our office accepts cash, credit card and check payments. Patients that do not have benefits through a third party may speak with the front desk attendant regarding our fees.

By signing this document, I acknowledge that I am responsible for the financial obligation arising from the provision of care to myself, or the person for whom I am acting as a personal representative (such as an unemancipated minor). I am assigning and authorizing payments to Total Spine and Rehab. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. There could/will be a rebilling fee of 30% of the total charges added to all accounts not paid in full within 90 days of service. I acknowledge I will incur the reasonable costs of collections including attorney’s fees should I fail to satisfy my financial obligation.

**HIPAA Privacy Notice / Communication**

Total Spine and Rehab requires a signed consent before sharing medical information with a third party. For exclusions to this policy, please ask a front desk staff member for a copy of our Notice of Privacy Practices. Details regarding the protection of patient privacy are detailed on that document.

There are times when TSR will need to contact you in order to provide you with appointment details and X-ray results. If you would like to opt out of receiving calls from us please let us know. Otherwise we will use the number provided to contact you. By signing below you agree that in order to service your account or collect monies owed, TSR and/or agents may contact you by telephone at any number associated with your account, including wireless numbers, which could result in charges to you. You may also be contacted through text messages or emails, if you provide them. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

**Testing / Consent to Treatment**

Your physician will determine what treatment is most appropriate to address your symptoms and condition. I voluntarily consent to the rendering of care, including treatment and performances of diagnostic procedures performed by the doctor or staff as appropriate. I understand TSR may refer me for diagnostic test (such as MRI) outside the office. I give consent for TSR to use my information to arrange such test, and I give consent that the results be released back to TSR for review. I understand the potential risk and consent to treatment. I understand I am free to ask questions about my treatment at any time. It is always your right to refuse any recommended test or treatment.

**Additional Medicare Consent**

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize and holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, and information needed for this or related Medicare claim.

**Female Waiver**

By my signature below on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. OR if I am pregnant, I will notify any and all technicians who will be performing X-rays or any other procedures.

I understand by signing this for, I am authorizing TSR to treat me as long as I seek treatment or until I withdraw my consent in writing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_