Encompass Chiropractic

1500 S. Georgia ◆ Amarillo, TX 79102 ◆ Phone: (806) 353-2106 ◆ Fax: (806) 353-6132

NEW PATIENT INFORMATION SHEET

Case #: *For Office Use Only			
Patient Name (First, MI, Last): **Preferred Name:**	**Date of Birth: (MM/DD/YY):**	**Social Security Number:**	
Mailing Address:	**Home Phone: Primary ? Y N**	**Cell Phone: Primary ? Y N**	
City: **State:** **Zip:**	**Marital Status: (Circle One):** Single Married Divorced Widowed	**Ethnicity:**	**Gender:** **M F**
Email Address:	**Work Phone:**	**Race: (Circle)** Hispanic Non-Hispanic	
Employment Status: (Circle): Full-Time Employed Part-Time Employed Student Retired	**Patient's Employer:**	**Occupation:**	
Emergency Contact: **Relationship:** **Phone #:**		**Employer's Address**	

Spouse's Name: (First, MI, Last)	**Spouse's DOB**	**Spouse's SSN:**	**Spouse's Cell:**
Spouse's Employer: **Spouse's Work Phone:**		**Other Household Members:**	

Responsible Party (Fill out only if other than patient.)			
Name:		**Relationship to Patient:**	
Address:		**Employer & Telephone Number:**	
Home Phone:	**Cell Phone:**	**SSN:**	**Date of Birth:**

Health Insurance Information – Information Must Be Complete For Filing			
Primary Insurance Health Care Plan:		**Secondary Insurance Health Care Plan:**	
ID#	**Group #**	**ID#**	**Group #**
Name of Policy Holder (First, MI, Last)		**Name of Policy Holder (First, MI, Last)**	
Policy Holder's Address:		**Policy Holder's Address:**	
Policy Holder's Phone Number:	**Policy Holder's Date of Birth:**	**Policy Holder's Phone Number:**	**Policy Holder's Date of Birth:**
Policy Holder's SSN:	**Relationship to Patient:**	**Policy Holder's SSN:**	**Relationship to Patient:**

Reason for Visit			
Date of Beginning of Symptoms:	**Is this related to an Accident?** **Y N**	**Was the Accident Reported?** **Y N When?**	**Reported to:** **Auto Carrier Work Other:**
Reason for Your Visit Today (include Areas of Pain)			

Referral Information		
How Did You Hear About Us?	**Primary Care Physician:** **Phone:** **Last Visit to PCP:**	
Have you seen a Chiropractor Before? **Y N**	**Chiropractor's Name:**	**Last Visit to Chiropractor:**

Patient Name: _____

SOCIAL HISTORY

Smoking: Packs per day _____ Alcohol: Drinks per day _____ Cups Per day: Soda _____ Coffee_____ Tea _____

Vitamins/herbs/Prescriptions (list all being taken): _____

Exercise (circle): None Moderate Daily Left handed Right handed Ambidextrous

PERSONAL & FAMILY HISTORY

Has any member of your family had any of the following diseases (circle & list who – i.e. mother, father, brother, sister, etc.)? Stroke_____

Diabetes_____ Kidney_____ Arthritis_____ Heart _____ Cancer _____

Lung _____ Neuropathy _____ Osteoporosis_____ Other _____

Have <u>you</u> had any of the following? (Please circle any applicable & list any requested information)

Stroke	Heart Disease	Peripheral Neuropathy	X-rays, MRI, CAT Scan of Spine (when & where)
Polio	Diabetes	Asthma	
Anemia	Arthritis	Seizure Disorder	Broken Bones/Dislocations (when & where)
Osteoarthritis	Hypertension	HIV AIDS	
Cancer	Alcoholism	Spinal Tap/Injection	Knocked Unconscious (when & how)
Appendicitis	Vertigo	Urinary Incontinence	

Please check or place an "X" for all symptoms that currently apply to you (Place a date for surgeries).

General Symptoms	Gastro-Intestinal	EENT	Surgeries & Surgery Date	Muscle & Joints
___ Headaches	___ Poor appetite	___ Poor vision	___ Tonsillectomy	___ Neck pain
___ Fever	___ Poor digestion	___ Pain in eyes	___ Tubes in ears	___ Back Pain
___ Night sweats	___ Excessive hunger	___ Deafness	___ Sinus	___ Joint Pain
___ Fainting	___ Belching or gas	___ Earache	___ Thyroid	___ Joint Swelling
___ Dizziness	___ Nausea	___ Ear noises	___ TMJ	___ Arm pain
___ Convulsions	___ Vomiting	___ Nosebleeds	___ Neck	___ Arm numbness/tingling
___ Loss of sleep	___ Stomach pain	___ Sore throat	___ Gall bladder	___ Limitation of Motion
___ Fatigue	___ Constipation	___ Hoarseness	___ Stomach	___ Leg pain
___ Loss of weight	___ Diarrhea	___ Hay fever	___ Appendectomy	___ Leg numbness/tingling
___ Allergies	___ Hemorrhoids	___ Asthma	___ Female organs	___ Muscular Weakness
___ Weakness	___ Liver trouble	___ Frequent colds	___ Hemorrhoids	___ Muscle Cramps/Spasms
___ Twitching	___ Jaundice	___ Thyroid trouble	___ Back	___ Painful tailbone
	___ Gall bladder	___ Tonsillitis	___ Hernia	___ Foot/Ankle pain
		___ Sinus trouble	___ Cataract	___ Scoliosis
			___ Vision correction	___ Shoulder Pain
Cardiovascular	**Skin**	**For Women Only**	___ Breast reduction	___ Elbow/Wrist Pain
___ Rapid heartbeat	___ Itching	___ Painful periods	___ Mastectomy	___Hip Pain
___ Slow heartbeat	___ Bruise easily	___ Excessive flow	___ Prostate	
___ High blood pressure	___ Dry skin	___ Irregular cycles		**Genito-Urinary**
___ Chest pain	___ Boils	___ Hot flashes	**Other Information: List**	___ Frequent urination
___ Swollen ankles	___ Sensitive skin	___ Cramps		___ Painful urination
___ Poor circulation	___ Hives	___ Vaginal discharge		___ Blood in urine
___ Varicose veins	___ Eczema	___ Breast implants		___ Kidney infections
___ Stroke		___ Pregnant How many weeks? _____		___ Bed wetting
___ Heart attack	**Respiratory**			___ Incontinence
___ ***Pacemaker***	___ Cough			___ Prostate trouble
	___ Short of breath			___ Bladder infections

Do you suffer from any condition other than that for which you are consulting us? (Additional information the doctor needs to know):

_____

Patient Name: _____

Health Insurance/Payment Information

I understand & agree that health & accident insurance policies are an arrangement between my insurance company & myself – not between my insurance company & this office. 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 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. In the even that I receive payment from the insurance, I understand that I am to remit payment to the Office immediately. If I fail to remit payment in full for monies received by an insurance company within 10 days of receipt, I understand that my account will be referred for prosecution to the full amount permitted by law. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that an interest charge at the highest allowable annual rate permitted by law will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect outstanding balance on my account from me or from any Payer, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to, all pre- and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office. **Initial: _____**

HIPAA RELEASE

I understand that some of my health information may be used and/or disclosed by Dr. J. Scott Verner, D.C. to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I can request a copy of the privacy notice entitled, "Our Privacy Practices," and that disclosures of my health information for any other reason must be agreed upon by me in writing,. I further understand that I can also revoke this consent in writing, but only to the extent that the Office has not taken action in reliance thereon. I understand that over time the Offices privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the revised notice, I can request a copy from the Office. A photocopy or fax of this consent is as valid as the original. **Initial: _____**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. Chiropractors commonly use their hands or a mechanical device in order to restore mobility and function of joints that are not moving or functioning optimally. For many patients certain therapies or exercises may also be used to maximize healing and pain relief.

Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen or having braces put on your teeth). Other rare but potential complications include muscular strain, fractures of bone, injury to intervertebral discs, nerves or spinal cord, or stroke/cerebrovascular injury (*estimated to be less than 1 in 2 million to 5.8 million cervical adjustments).* Complications from therapies used in addition to your adjustment are rare, but may cause skin irritation, burns, soreness, or other minor complications.

Risk of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or spine injury.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction before initialing. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent for the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. **Initial: _____**

I have read, understood, and agree to the foregoing. The information, which I have provided, is true & complete to the best of my knowledge.

Patient's Signature:_____ **Date:**_____/_____/_____

CONSENT TO TREATMENT OF A MINOR

(The minor is the patient listed on first page of this document)

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize **Dr. J. Scott Verner, D.C.** to administer treatment as he so deems necessary to the minor from this day forward unless I revoke my consent in writing. In the event that the minor has received treatment at this practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **Dr. J. Scott Verner, D.C.'s office**, which are customarily completed and signed by patients as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please print & spell clearly):_____

Relationship to the minor: Custodial Parent____ Adoptive Parent with custody____ Other (please specify):_____

Guardian by Law____ Date guardianship commenced _____/_____/_____

SS# Of Parent/Guardian_____-_____-_____ Date of Birth of Parent/Guardian_____/_____/_____

Address of Parent/Guardian_____

Home phone: (_____)_____-_____ Work phone: (_____)_____-_____

Signature:_____ **Date:**_____/_____/_____

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOU DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. **I authorize Encompass Chiropractic to disclose my protected health information to:**

   _____ **Family member(s) (List):** _____ **Ph#:** _____

   _____ **Ph#:** _____

   _____ **Non- family member(s) (List):** _____ **Ph#:** _____

   _____ **Myself only**

2. **I authorize the practice to disclose only the following protected health information to the individual(s) listed above:**

   _____ **Test results, reports, and general health updates**

   _____ **Nothing beyond general health questions & updates**

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

_____ _____

Patient/Authorized Individual Signature **Date**