

Weis Chiropractic Health Center
CONFIDENTIAL New PATIENT INFORMATION FORM
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Instructions

The information on these documents is kept in your confidential patient file in our office as a record of your office visit.

After printing the documents, please fill them out completely. Bring the completed and signed documents with you to your office visit. By doing so you'll be able to speed up the initial registration process as a new patient.

Patient Details

Last Name: _____ **First Name:** _____ **Middle:** _____
Marital Status: Married Single Divorced Widowed
Birth Date: ___/___/___ **SSAN:** _____/_____/_____
Address: _____ **Phone:** _____
City: _____ **State:** _____ **Zip Code:** _____
Email Address: _____ **Occupation:** _____
Employer Name: _____
Employer Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone: _____
Name of Spouse (parent, if you are a minor): _____ **Phone:** _____
Primary Care Physician: _____ **Phone:** _____
Insurance Provider: _____ **Phone:** _____ **ID#:** _____

Visit Details

Chief Complaint: _____
Date Problem Started: _____ **Auto Accident Related:** Yes No **Work Related:** Yes No
Since your last visit have you required surgery or hospitalization? Yes No **If yes, please explain briefly the details:** _____
Since your last visit have you required treatment from another physician? Yes No **If yes please explain briefly the details:** _____
Do you suspect that you may be pregnant? Yes No
Are you currently taking any over the counter medications? Yes No **Explain:** _____
Are you currently taking medications for the following: Anti-inflammatory Muscle Relaxants Birth Control
Blood Thinners High Blood Pressure Pain Relievers
Other Explain: _____
Have you ever been diagnosed with: High Blood Pressure Heart Attack Emphysema Seizures/Convulsions
Thyroid Disease Circulation Problems Cancer (If yes, please describe type of cancer): _____

Please note: payment or insurance co-payment is expected at time of visit.

Patient Signature / Date

New Patient Symptom Assessment
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Patient Full Name: _____

DOB: _____ Date: _____

Do you suspect you may be pregnant? Yes No

Do you have chest pain? Yes No

Do you have any unusual bleeding or discharge? Yes No

Do you have a nagging cough or hoarseness? Yes No

Do you have headaches for hours or days? Yes No

Do you have blurred vision? Yes No

Do you have pain in your jaw or face? Yes No

Do you have dizziness? Yes No

Do you suffer from slurred speech? Yes No

Do you have mid-back pain? Yes No

Do you have shortness of breath? Yes No

Do you fatigue easily? Yes No

Do you suffer from depression? Yes No

Does your pain ever wake you from a sound sleep? Yes No

Are you losing weight without trying? Yes No

Are you coughing up blood or noticing it in your urine or stool? Yes No

Do you smoke? Yes No If yes, how long? _____ How many packs per day? _____

Do you drink alcohol? Yes No If yes, how much? _____

Are you allergic to any foods or drugs? Yes No

If yes, what? _____

Substance abuse? Yes No

What prescription medication(s) are you currently taking, if any?

- () High blood pressure medication () Muscle Relaxers
- () Anti-inflammatory medication () Blood thinners
- () Pain Medication () Birth control pills
- () Other

What over the counter medication(s) have you been taking?

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List any of your past surgical procedures, if any, and the date in which they were performed.

List any past injuries, if any, and the date in which they occurred.

Are you seeing another doctor for any other reason? Yes No Comments:

Did you, your mother or your father have any of the following? (Circle **M** for mother, **F** for father, **S** for self):

High blood pressure	M	F	S
Heart Attack	M	F	S
Emphysema	M	F	S
Seizures-Convulsions	M	F	S
HIV Positive	M	F	S
Asthma	M	F	S
Diabetes	M	F	S
Kidney disease	M	F	S
Ulcer or stomach problems	M	F	S
Stroke	M	F	S
Arthritis-Rheumatism	M	F	S
Mental illness	M	F	S
Thyroid disease	M	F	S
Circulation problems	M	F	S
Cancer	M	F	S

Patient Signature

CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and authorize Dr. _____ at Weis Chiropractic Health Center to perform diagnostic tests and render chiropractic adjustments and other treatment. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I Authorize Payment of Any Medical Benefits from _____ to be Paid Directly to This Chiropractic Clinic for Any Service Rendered to Me.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect sums due for the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. I hereby waive the statute of limitations on collection regarding my case and care.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed are paid in full.

MEDICAL RECORDS RELEASE

KNOW ALL MEN BY THESE PRESENTS: That I, _____, hereby authorize the release of my medical/chiropractic records or copies of the same to such parties the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

DATE _____

SIGNATURE _____

WITNESS _____