

Weis Chiropractic Health Center  
**CONFIDENTIAL PATIENT INFORMATION FORM – ROP**  
10671 McSwain Drive  
Cincinnati, OH 45241  
Voice: 513.563.0414 FAX 513.563.9540 Web: [www.weischiro.com](http://www.weischiro.com)

## **Instructions**

The information on these documents is kept in your confidential patient file in our office as a record of your office visit. These documents are to be submitted when you have not visited our office during the current calendar year.

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 of your office visit.

**Patient Details**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_  
**Marital Status:**  Married  Single  Divorced  Widowed  
**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:** \_\_\_\_\_

**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

**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 \_\_\_\_\_