PATIENT INFORMATION

Please take a moment to fill out all the information below. Thank you!

Name_____**Date**_____

Date of Birth_____**Age**_____**Sex** □ **Male** □ **Female**

Address_____

City_____**State**_____**Zip Code**_____

Home Phone_____**Cell**_____**E-Mail**_____

Name of Emergency Contact_____**Relation**_____ **Phone**_____

Check One: □ **Married** □ **Single** □ **Widowed** □ **Separated** □ **Divorced** □ **W/ Children (if so ages)**_____

Social Security #_____-_____-_____ **- (Required)**

How did you hear about our practice? □ **Friend/Relative > Please Specify**_____

□ **Massage Client** □ **Direct Mail** □ **Drive By** □ **Email** □ **Facebook** □ **Signs/Billboards** □ **Internet** □ **Gift** □ **Promotion**

□ **Nutrition Client** □ **Corporate Program** □ **PT Client** □ **Health Insurance** □ **MD Referral** □ **Attorney Referral**

□ **Member Referral** □ **Employee Referral** □ **Other > Please Specify**_____

Business/Employer_____

Address_____

Type of Work_____**Years Employed**_____**Retired (Date)**_____

Who is your Primary Care Physician? _____

Phone #_____**Fax #**_____

Who is your referring Physician? (If different than your PCP)_____

Phone #_____**Fax #**_____

Please answer the following Government Question:

What is your race: □ **Caucasian** □ **Black** □ **Asian** □ **Pacific Islander** □ **Hispanic** □ **REFUSE TO ANSWER**

What is your Religion?_____**What is your Native Language?**_____

INSURANCE / PAYMENT INFORMATION

Who is responsible for your bill?

□ **Self** □ **Spouse** □ **Parent** □ **Workmans' Comp** □ **Auto** □ **Other**_____

Do you have health insurance? □ **Yes** □ **No**

Primary Insurance_____**ID #:** _____

Insured Name (if different then yourself)_____**Group Number**_____

Patient is the □ **Self** □ **Spouse** □ **Child** □ _____**to the insured / Insured.**

DOB_____

Secondary Insurance: _____**ID #:** _____

PLEASE INDICATE WHICH CONDITIONS EXIST OR HAVE EXISTED

FAMILY HISTORY							
	Self	MOTHER	FATHER	SISTER	BROTHER	SON	DAUGHTER
Cancer – Specify:	□	□	□	□	□	□	□
Cancer – Specify:	□	□	□	□	□	□	□
Cancer – Specify:	□	□	□	□	□	□	□
Clotting Disorder	□	□	□	□	□	□	□
Deep Vein Thrombosis	□	□	□	□	□	□	□
Pulmonary Embolism	□	□	□	□	□	□	□
Dementia / Alzheimer's	□	□	□	□	□	□	□
Gestational Diabetes	□	□	□	□	□	□	□
Impaired Fasting Glucose	□	□	□	□	□	□	□
Insulin Resistance	□	□	□	□	□	□	□
Maturity Onset Diabetes (MODY)	□	□	□	□	□	□	□
Pre-Diabetes	□	□	□	□	□	□	□
Type 1 Diabetes	□	□	□	□	□	□	□
Type 2 Diabetes	□	□	□	□	□	□	□
Colon Polyp	□	□	□	□	□	□	□
Chron's Disease	□	□	□	□	□	□	□
Familial Adenomatous Polyposis	□	□	□	□	□	□	□
Gastrointestinal Disorder	□	□	□	□	□	□	□
Irritable Bowel Syndrome	□	□	□	□	□	□	□
Ulcerative Colitis	□	□	□	□	□	□	□
Lynch Syndrome	□	□	□	□	□	□	□
Angina	□	□	□	□	□	□	□
Coronary Artery Disease	□	□	□	□	□	□	□
Heart Attack	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
Chronic Kidney Disease	□	□	□	□	□	□	□
Congenital Kidney Disease	□	□	□	□	□	□	□
Kidney Nephrosis	□	□	□	□	□	□	□
Nephritis	□	□	□	□	□	□	□
Nephrotic Syndrome	□	□	□	□	□	□	□
Stroke / Brain Attack	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□
COPD	□	□	□	□	□	□	□
Chronic Bronchitis	□	□	□	□	□	□	□
Chronic Lower Respiratory Disease	□	□	□	□	□	□	□
Emphysema	□	□	□	□	□	□	□
Influenza	□	□	□	□	□	□	□
Pneumonia	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□
Anxiety	□	□	□	□	□	□	□
ADHD	□	□	□	□	□	□	□
Autism	□	□	□	□	□	□	□
Bipolar Disorder	□	□	□	□	□	□	□
Dementia	□	□	□	□	□	□	□
Depression	□	□	□	□	□	□	□
Eating Disorder	□	□	□	□	□	□	□
Mental Disorder	□	□	□	□	□	□	□
Personality Disorder	□	□	□	□	□	□	□
Pace Maker	□	□	□	□	□	□	□
PTSD	□	□	□	□	□	□	□
Schizophrenia	□	□	□	□	□	□	□
Septicemia	□	□	□	□	□	□	□

PATIENT HISTORY

Please describe your past accidents

1. ***Accident***_____***Date***_____
2. ***Accident***_____***Date***_____
3. ***Accident***_____***Date***_____

Please describe your past surgeries

1. ***Surgery***_____***Date***_____
2. ***Surgery***_____***Date***_____
3. ***Surgery***_____***Date***_____

Do you have any implants? □ Yes □ No If yes, please describe_____

Are you currently pregnant? □ Yes □ No If yes, please list your due date_____

PLEASE INDICATE WHICH CONDITIONS YOU HAVE EXPERIENCED

AIDS	□	**Allergies**	□	**Anemia**	□	**Arthritis**	□
Asthma	□	**Back Pain**	□	**Bladder Trouble**	□	**Bone Fracture**	□
Caner	□	**Chest Pain**	□	**Concussion**	□	**Constipation**	□
Convulsions	□	**Depression**	□	**Diarrhea**	□	**Dislocated Joints**	□
Epilepsy	□	**Fibromyalgia**	□	**German Measles**	□	**Headache**	□
Heart Trouble	□	**Hepatitis**	□	**Herniated Disk**	□	**High Blood Pressure**	□
High Cholesterol	□	**HIV/ARC**	□	**Kidney Disorder**	□	**Lower of Bowel Control**	□
Lung Disease	□	**Menstrual Cramps**	□	**Migraine Headaches**	□	**Multiple Sclerosis**	□
Muscular Dystrophy	□	**Neck Pain**	□	**Nervousness**	□	**Numbness**	□
Osteoporosis	□	**Parkinson's Disease**	□	**Pinched Nerve**	□	**Polio**	□
Poor Circulation	□	**Reproductive Disorder**	□	**Rheumatic Fever**	□	**Rheumatism**	□
Rheumatoid Arthritis	□	**Reproductive Disorder**	□	**Scoliosis**	□	**Serious Injury**	□
Sinus Trouble	□	**Scarlet Fever**	□	**Thyroid Problems**	□	**Tuberculosis**	□
Tumors or Growths	□	**Ulcers**	□	**Venereal Disease**	□	**Pregnant**	□

SYMPTOMS

Neck Pain	□	**Upper Back Pain**	□	**Mid Back Pain**	□	**Lower Back Pain**	□
Stiff Neck		**Headaches**	□	**Dizziness**		**Vertigo**	
Left Shoulder Pain	□	**Right Shoulder Pain**	□	**Left Elbow Pain**	□	**Right Elbow Pain**	□
Left Hand Pain	□	**Right Hand Pain**	□	**Left Hip Pain**	□	**Right Hip Pain**	□
Left Knee Pain	□	**Right Knee Pain**	□	**Left Foot Pain**	□	**Right Foot Pain**	□

IMPAIRED ACTIVITIES

Computer Use	□	**Drawing**	□	**Concentrating**	□	**Cycling**	□
Desk Work	□	**Piano**	□	**Driving**	□	**Exercise**	□
Lying Down	□	**Standing**	□	**Reading**	□	**Running**	□
Sitting	□	**Yard Work**	□	**Staying Asleep**	□	**Using the Phone**	□
Walking	□	**Cervical Range of Motion**	□	**Bathing**	□	**Bending**	□
Caring For Infant	□	**Dressing**	□	**Child Care**	□	**Climbing Stairs**	□
Falling Asleep	□	**Lifting**	□	**Golf**	□	**Hair Care**	□
Kneeling	□	**Lying Down**	□	**Lifting Children**	□	**Lifting / Carrying**	□
Looking Over Shoulder	□	**Needlework**	□	**Pet Care**	□		□

SYMPTOM 1

Please elaborate on one of the symptoms from previous page

Indicate Symptom_____**Date of Onset**_____

Pain Rating (1-10 w/ 10 being the worst pain you can imagine) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Main impaired activity made more difficult by above symptom_____

Pain Cause □ Fall □ Work Injury □ Auto Injury □ Illness □ Lifting □ Gradual Onset

Pain Duration □ _____Day(s) □ _____Week(s) □ _____Month(s) □ _____Year(s)

Pain Quality □ Aching □ Burning □ Cramping □ Deep □ Diffuse □ Dull
□ Radiating □ Sharp □ Shooting □ Stiffness □ Tight □ Tingling/Numbness

Pain Frequency □ Constant □ Frequent □ Intermittent □ Occasional

Pain Pattern □ Better in Morning □ Better in Afternoon □ Better in Evening □ Consistent
□ Worse in Morning □ Worse in Afternoon □ Worse in Evening □ Unchanged

Pain Radiates □ Left Shoulder □ Left Arm □ Left Hand □ Right Shoulder □ Right Arm □ Right Hand
□ Left Hip □ Left Knee □ Left Foot □ Right Hip □ Right Knee □ Right Foot

Pain Aggravated By □ Bending □ Driving □ Getting Up □ Increased Activity □ Looking down
□ Reaching □ Sitting □ Standing □ Overhead Activities □ Typing
□ Coughing □ Exercising □ House Work □ Preparing Food □ Sneezing
□ Walking □ Twisting □ Resting □ Lying Down □ _____

Pain Relieved By □ Exercise □ Medication □ Stretching □ Turning Head □ Walking
□ Head □ Ice □ Support □ Knees Bent Up □ Lying Down
□ Lifting □ Reaching □ Ibuprofen □ No Movement

Previous Treatments □ Medication □ Chiropractic □ Surgery □ Physical Therapy □ Massage Therapy

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Symptom Reviewed On_____**By**_____

SYMPTOM 2

Please elaborate on one of the symptoms from previous page (leave blank if you only have one)

Indicate Symptom_____**Date of Onset**_____

Pain Rating (1-10 w/ 10 being the worst pain you can imagine) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Main impaired activity made more difficult by above symptom_____

Pain Cause □ Fall □ Work Injury □ Auto Injury □ Illness □ Lifting □ Gradual Onset

Pain Duration □ _____Day(s) □ _____Week(s) □ _____Month(s) □ _____Year(s)

Pain Quality □ Aching □ Burning □ Cramping □ Deep □ Diffuse □ Dull
□ Radiating □ Sharp □ Shooting □ Stiffness □ Tight □ Tingling/Numbness

Pain Frequency □ Constant □ Frequent □ Intermittent □ Occasional

Pain Pattern □ Better in Morning □ Better in Afternoon □ Better in Evening □ Consistent
□ Worse in Morning □ Worse in Afternoon □ Worse in Evening □ Unchanged

Pain Radiates □ Left Shoulder □ Left Arm □ Left Hand □ Right Shoulder □ Right Arm □ Right Hand
□ Left Hip □ Left Knee □ Left Foot □ Right Hip □ Right Knee □ Right Foot

Pain Aggravated By □ Bending □ Driving □ Getting Up □ Increased Activity □ Looking down
□ Reaching □ Sitting □ Standing □ Overhead Activities □ Typing
□ Coughing □ Exercising □ House Work □ Preparing Food □ Sneezing
□ Walking □ Twisting □ Resting □ Lying Down □ _____

Pain Relieved By □ Exercise □ Medication □ Stretching □ Turning Head □ Walking
□ Head □ Ice □ Support □ Knees Bent Up □ Lying Down
□ Lifting □ Reaching □ Ibuprofen □ No Movement

Previous Treatments □ Medication □ Chiropractic □ Surgery □ Physical Therapy □ Massage Therapy

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Symptom Reviewed On_____**By**_____

Financial Agreement and Authorization for Assignment of Benefits & Patient Consent

Name_____**Date**_____

1. CANCELLATION POLICY: Due to the significant number of people that we have waiting to be seen and frequent problems with patients that either do not show up for their appointments or cancel at the last minute, we have to advise you that we will have to start charging for missed appointments. You will be required to call our office at least 24 hours prior to your appointment to cancel. If you fail to call our office 24 hours prior to your appointment, you will be charged $25.00. This charge will not be billed to your insurance company. You will be financially responsible for this charge.

2. FINANCIAL AGREEMENT: I agree to pay for all services rendered to me by Smith Chiropractic & Wellness Center LLC. I understand that as a courtesy to its patients providing insurance/billing information, Smith Chiropractic & Wellness Center LLC will submit claims to my health care plan or insurance company. However, I further understand that I am responsible for payment of the balance owed. I agree that I am also responsible for any deductibles, co-insurance, charges for non-covered services, charges for services deemed "medically unnecessary" or charges for which I have not obtained a properly authorized written referral, if required by my health plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services.

FOR MEDICARE PATIENTS ONLY
3. MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits due me be paid in my behalf Smith Chiropractic & Wellness Center LLC, for any services furnished by Smith Chiropractic & Wellness Center LLC. I authorize any holder of medical or other information about me to release to any insurance carrier or to the Health Care Financing Administration and its agents, information needed to determine these benefits or any benefits for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for the Medicare Part B deductible and the remaining 20% of charges.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Smith Chiropractic & Wellness Center LLC those insurance benefit payments due to Smith Chiropractic & Wellness Center LLC and hereby authorize my insurance company to make payment directly to Smith Chiropractic & Wellness Center LLC. I understand that regardless of this assignment, I remain primarily responsible to Smith Chiropractic & Wellness Center LLC for payment of all actual charges incurred. A carbon copy or photocopy of this assignment shall be as valid as the original.

5. PATIENT CONSENT: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapeutic, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at Smith Chiropractic & Wellness Center LLC. I have had I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise his/her educated judgement during the course of the procedure which the doctor feels t the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

6. USE OF PHOTOS: I acknowledge that from time to time, Smith Chiropractic & Wellness Center LLC may take photographs of me participating in programs or activities offered by the Department for use and publication in various publications or media, including but not limited to Smith Chiropractic & Wellness Center LLC website, department program brochures, promotional marketing materials, and I hereby expressly grant to Smith Chiropractic & Wellness Center LLC the right to use and publish such photographs as contemplated herein, all without compensation or payment for such use and publication

7. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I understand and have been provided with a *Notice of Information* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent; The right to object to the use of my health information for directory purposes; and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ OR HAVE HAD THE ABOVE INFORMATION EXPLAINED TO ME AND THAT I FULLY UNDERSTAND THE STATEMENTS IN THIS DOCUMENT AND CONSENT TO EACH OF THEM. I CERTIFY THAT I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT THE TERMS.

_____ _____

Patient Signature / Representative **Date**

AUTHORIZATION TO RELEASE / REQUEST HEALTHCARE INFORMATION

Patient's Name_____**DOB**_____

Previous Name_____**DOB**_____

I authorize Smith Chiropractic & Wellness Center LLC to release and request the following healthcare information to:

□ All Records □ X-rays □ MRI Films □ Bloodwork □ Other _____

__x__Fax Report __x__Mail CD/Films

SMITH CHIROPRACTIC & WELLNESS CENTER

DR. TRISTAN SMITH DC

3443 PENN AVE, SINKING SPRING, PA 19608

PHONE: 610-678-8600

FAX: 610-678-4747

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 2 years from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

I DO UNDERSTAND THAT THE RELEASING OFFICE / FACILTY MAY CHARGE A FEE FOR THESE RECORDS. THIS FEE IS NOT IN ASSCIATION WITH SMITH CHIROPRACTIC & WELLNESS CENTER LLC.

_____ _____

Patient Signature Patient's Agent / Representative **Date**

_____ _____

Address **DOB**

_____ _____

City, State, Zip Code **SSN**