CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City _____ Zip _____

Home Phone _____ Cell _____ E-Mail _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Children, Ages _____

Occupation _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name_____ Number _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

NAME _____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION

DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date_____

Date_____

Date_____

Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	☐	Epilepsy	☐
Mumps	☐	Paralysis	☐
Rheumatic Fever	☐	Polio	☐
Allergies	☐	Mental Illness	☐
Angina	☐	Alcoholism	☐
Cancer	☐	Depression	☐
Tumor	☐	Nervous Breakdown	☐
Blood Disease	☐	Migraine	☐
Leukemia	☐	Gout	☐
Heart Trouble	☐	Hemorrhoids	☐
Varicose Veins	☐	Prostate Problems	☐
Phlebitis	☐	Sexual Problems	☐
Hypertension	☐	Gonorrhea	☐
Stroke	☐	Syphilis	☐
Ulcers	☐	Diabetes	☐
Jaundice	☐	Bladder Trouble	☐
Skin Trouble	☐	Kidney Stones	☐
Gallstones	☐	Kidney Infections	☐
Liver Trouble	☐	Emphysema	☐
Hepatitis	☐	Bladder Trouble	☐
Parasites	☐	Dysentery	☐
Tuberculosis	☐	Other _____	☐

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies: _____

_____

_____

_____

_____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Patient Name _____ Number _____ Date _____

Jordan CHIROPRACTIC Center

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain Is preventing you from doing what you would normally do, or from doing It as well as you normally would. Respond to each category by Indicating the overs//Impact of pain In your life, not Just when the pain Is at Its worst

For each of the six categories of dally living listed. PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities In which you would normally be Involved have been totally disrupted or prevented by your pain.

---

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It Includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out. and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. ***Self Care.*** This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. ***Life-Support Activity***. This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE: _____SIGNATURE: _____DATE: _____

For re-ordering information, contact:
Activator Methods International. Ltd. 3714 E. Indian School Road Phoenix, AZ 85018
Phone: (800) 598-0224 · (602) 224-0230 · Fax: (602) 224-0230 E-mail: sales@activator.com
REVISED MARCH 15.1993

Jordan CHIROPRACTIC Center

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire Is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain Is mild and does not vary much.
C. The pain comes and goes and Is moderate.
D. The pain Is moderate and does not vary much.
E. The pain comes and goes and Is severe.
F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though It causes some pain.
C. Washing and dressing Increases the pain, but I manage not to change my way of doing It
D. Washing and dressing increases the pain and I find It necessary to change my way of doing It
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but K causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage If they are conveniently positioned, e.g.,on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 - Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than1/2 mile.
D. Pain prevents me from walking more than 1/4i mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet

SECTION 5 - Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 how.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but K does not Increase with time
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than % hour without Increasing pain.
E. I cannot stand for longer than ten minutes without increasing pain.
F. avoid standing, because It increases the pain straight away.

SECTION 7 - Sleeping

A. I get no pain In bed.
B. I get pain In bed, but It does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but Increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic Interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 - Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I got extra pain while traveling, which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

Comments: _____

Patient's Signature: _____ Date: _____

Jordan CHIROPRACTIC Center

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire Is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. Tho pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care

A. I can look after myself normally without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need come help, but manage most of my personal care.
E. I need help every day In most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay In bed.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage If they are conveniently positioned, e.g., on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights If they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 - Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot reaad as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches

A. I have no headaches at all.
B. I have slight headaches, which come infrequently.
C. I have moderate headaches, which come infrequently.
D. I have moderate headaches, which come frequently.
E. I have severe headaches, which come frequently.
F. I have headaches almost all the time.

SECTION 6 - Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty In concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 - Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 - Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want slight pain in my neck.
C. I can drive my'car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 - Sleeping

A. I have no trouble sleeping.
B. My sleep if slightly disturbed (less than 1 hour sleepless).
C. My sleep mildly disturbed (1-2 hours sleepless).
D. My sleep Is moderately disturbed (2-9 hours sleepless).
E. My sleep Is greatly disturbed (3-5 houts sleepless).
F. My sleep Is completely disturbed (6-7 hours sleepless).

SECTION 10 - Recreation

A. I am able to engage In all of my recreational activities, with no neck pain at all.
B. I am able to engage In all of my recreational activities, with some pain In my neck.
C. I am able to engage in most, but not all of my usual recreational activities because of pain In my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

After Vernon & Mior. 1991
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REVISED 1/1/95

Comments: _____

Patient's Signature: _____ Date: _____

Jordan Chiropractic Center

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

RELEASE OF INFORMATION

By signing this form, I am granting consent to Jordan Chiropractic Center as well as other health care facilities where I have been treated to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Information Privacy Practices provides more detailed information about how we may use and disclose this protected health information and you have a legal right to review the notice before you sign this consent, and we encourage you to read it in full. You have the right to revoke this consent, except to the extent we already have used or disclose your protected health information in reliance on your consent.
By signing this form, I am attesting that I agree to this release of information and have read, understand, and agree to the Notice of Information Privacy Practices.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

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

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign you insurance benefits directly to us. This policy reduces your out of pocket expense and allows you to place your family under care. If you have not paid your balance within 60 days, we reserve the right to refuse or terminate care.
If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Our payments plans make care an affordable part of your family budget.
If You Have Insurance: Insurance quotes obtained by our office are not a guarantee of payment, but only a quote of the member contract. Specific claims are subject to review for medical necessity by individual insurance companies. Any balance that insurance does not pay will be the responsibility of the patient. All deductibles are co-payments are expected at the time of service, or by an authorized payment plan. You are considered a cash patient until you bring in your insurance card, and we qualify and accept your insurance coverage. Our fees are considered usual, customary, and reasonable by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area. If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If you carrier has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance. When your schedule of visits is once per month or longer, you may not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you.
By signing this form, I am attesting that I have read, understand, and agree to the financial policy.

Verfication of Non-Pregnancy (female patients only): By signing 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.

X _____ Date: _____
Print Patient's Name

X_____ _____
Sign Patients Name Other than patient, print name and relationship

X _____
Office Witness

Jordan Chiropractic Center

NOTICE OF INFORMATION PRIVACY PRACTICES

Protecting the privacy of your personal information is important to us. This notice describes how information about you may be used and disclosed and how you can access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will bed made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office at 304-768-7671.

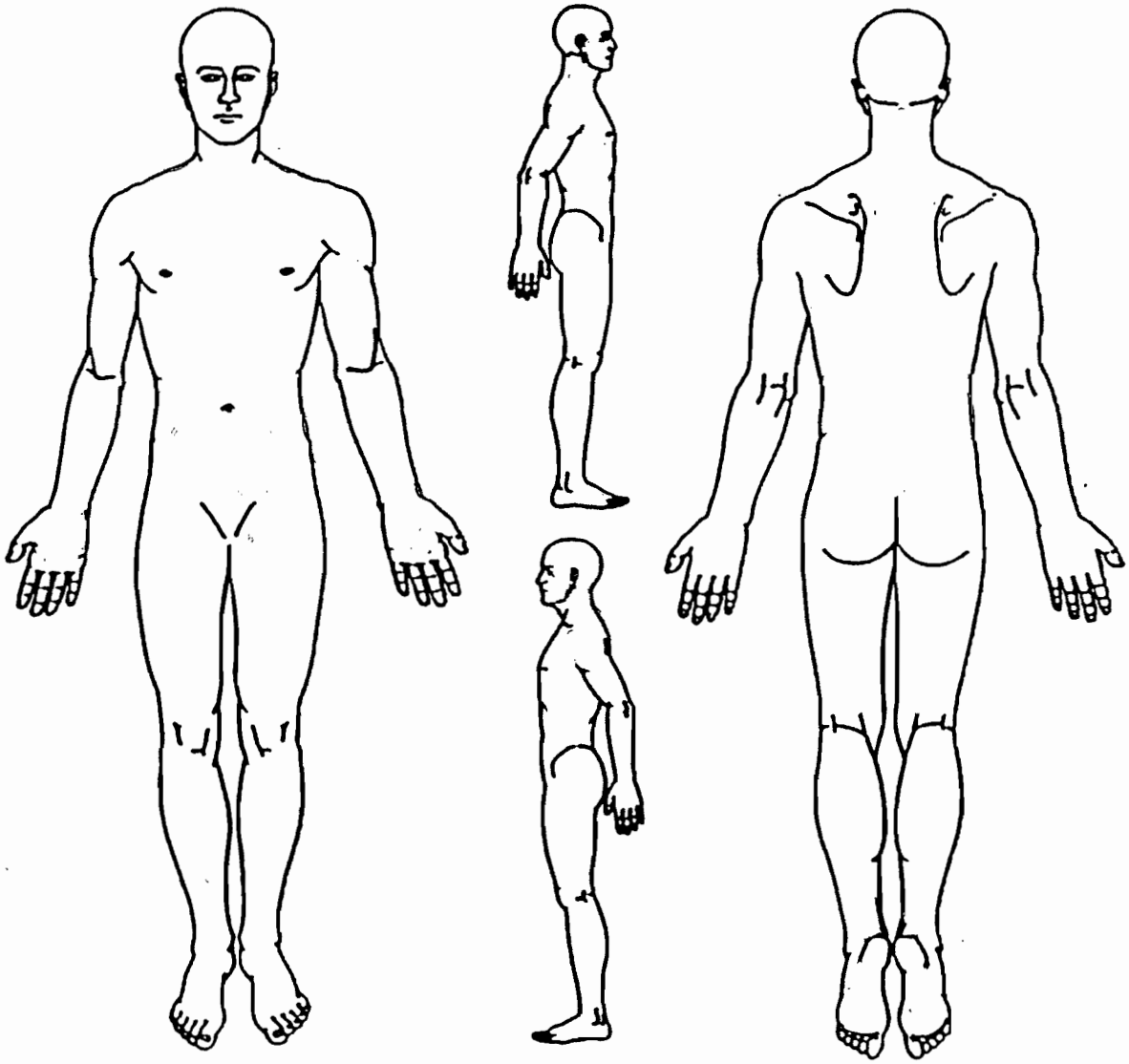
The effective date of this Notice of Information Practices is the date you sign the consent to treat form.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 304-768-7671. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to do so, we are bound by our agreement.

Where is your pain? How does it feel? Draw your pain using the following key.

KEY

/ / / Stabbing	X X X Burning	000 Pins and Needles	▲▲▲ Aching, Throbbing	= = = Numbness	• • • Other



Signature _____ Date _____

PATIENT INFORMATION

Patient Name: _____

Address: _____ Doctor: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Social Security#: _____

Sex: _____ Marital Status: _____ DOB: _____

Referring Physician/ UPIN #: _____

Employment Status: Retired ❑ Not Employed ❑ Full Time ❑ Part Time ❑

Employer Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Student Status: Full Time ❑ Part Time ❑ Non Student ❑

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Sex: _____ Marital Status: _____

Relationship to Patient: _____ Policy or Group #: _____

Identification #: _____ Policy Type: Employer ❑ Group ❑ Non-Group ❑

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Work Phone #: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Sex: _____ Marital Status: _____

Relationship to Patient _____ Policy or Group #: _____

Identification #: _____

Policy Type: Emp ❑ Group ❑ Non-Group ❑ Medigap ❑ Medicaid ❑ Supplement ❑ MedicareSec ❑

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Work Phone #: _____

Please include any additional insurance information on the back of this sheet.

I authorize release of any information necessary to process my insurance claims. I assign and request payment directly to my physician(s).

Signature: _____ Date: _____