ADVANTAGE *Spine & Disc*

Confidential Patient Information

First Name _____ Nick Name _____ Date _____

Last Name _____ Middle Name _____ Suffix _____

Patient Title: (check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

Address _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

Home Phone # (____)_____ Cell # (____)_____ Work # (____)_____

Home Email _____ Work Email _____

Contact Method (check one) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Personal Email ☐ Work Email

☐ **I wish to receive text message reminders for my appointments.**

☐ **I wish to receive email message reminders for my appointments.**

D.O.B. (mo/day/yr) _____/_____/_____ Age _____ Gender (check one) ☐ Male ☐ Female ☐ Unspecified

Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____

Social Security # _____ -_____ - _____ Employer _____ Address _____

Employment Status (check one) ☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

Spouse's Employer _____ Phone #(____)_____ Spouse SS # _____ -_____ - _____

Emergency Contact _____ Phone # (____)_____

Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one)

☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native
☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian or other Pacific Island
☐ Samoan ☐ Guamanian or Chamorro ☐ Other_____ ☐ I choose not to specify

Preferred Language (check one)

☐ English ☐ Spanish ☐ American Sign Language ☐ Chinese ☐ French ☐ German
☐ Tagalog ☐ Vietnamese ☐ Italian ☐ Korean ☐ Russian ☐ Polish
☐ Arabic ☐ Portuguese ☐ Japanese ☐ French Creole ☐ Greek ☐ Hindi
☐ Persian ☐ Urdu ☐ Gujarati ☐ Armenian ☐ I choose not to specify

Do you currently use tobacco of any kind? ☐ Yes ☐ Former smoker/user ☐ Never been a smoker/user

If yes, how often do you smoke/use: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking: no interest ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 very interested

How did you find out about our office/who referred you to us? _____

☐ Friend/Family ☐ Doctor ☐ TV ☐ Internet ☐ Sign ☐ Phonebook ☐ Home Mailer ☐ Newspaper (please give ad to front desk)

Is your visit due to an accident? ☐ No ☐ Yes (if yes, please see receptionist for an injury report.)

Your Present Complaint _____

How did your symptoms start? _____ _____

_____

List other doctor(s) seen for this condition _____

Medical History (if any of the following are relevant to your medical history, please check the accompanying box)

☐ Allergies	☐ Concussion	☐ Heart Trouble	☐ Numbness
List:_____	☐ Convulsions	☐ Hepatitis	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Digestive Disorders	☐ Multiple Sclerosis	☐ Scarlet Fever
☐ Backaches	☐ Dizziness	☐ Muscular Dystrophy	☐ Sinus Trouble
☐ Cancer	☐ Epilepsy	☐ Nervousness	☐ Tuberculosis

Describe any operations you've had (and dates): _____

_____

Have you been treated by a physician for any health condition in the last year? ☐ No ☐ Yes
Describe condition: _____ Date of last physical exam _____

Current medications, including dosage. If there are no medications check here: ☐

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

List any known allergies you have had to any medications. If no allergies are known, check here: ☐

1) _____ 2) _____

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No If yes, describe _____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II
If yes to Diabetes, was your blood lab-work test hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

Have you had any other X-ray or CT scan or MRI in the past year? ☐ Yes ☐ No if yes, describe _____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period _____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Do you have insurance? ☐ Yes ☐ No Company _____
Policy Number _____ Group Number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Advantage Walk-In Chiropractic extends credit to me, and I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I understand that if my account is 60 days past due an $5 late fee will be assessed per billing cycle and any accounts 120 days past due will be forwarded to our collections department and will be subject to collection-processing fees. If my check is dishonored I understand that a $25 processing fee will be assessed to my account. I hereby authorize the doctors at Advantage Walk-In Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____

Advantage Spine & Disc -- Jamie M. Ricks, D.C.

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive payment and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions. But if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature_____Date_____

Restrictions: