University Chiropractic and Wellness, LLC

Patient Information:

Last Name:_____First Name:_____(M):_____
Address:_____City:_____
State:_____Zip:_____Birth Date:_____/_____/_____ SS#_____/_____/_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Occupation:_____Employer:_____

Responsible Party: Patient ☐ Parent ☐ Spouse ☐

Name of Repsonsible Party if not patient: _____ DOB:_____/_____/_____
Employer:_____Work Phone:_____ SS#_____/_____/___

****If you are a student please put your parents' home mailing address if not listed above:**

_____

How were you referred to our office? (Please X one of the following)
_____Friend, family member or a patient. May we have their name so we can send them a thank you letter.

Referrer's Name: _____

If you weren't referred by a friend or family member how did you find our office?

_____Google Search _____Google ad _____Office Sign _____Attorney _____Another Physician

_____yelp _____Groupon ____Facebook _____Phone Book Other_____

Have you ever been to a Chiropractor before? ☐yes ☐ no
If yes, for what and how long ago_____

Please X any and all Insurance coverage that may be applicable in this case:
☐Major Medical (Blue Cross or other Health Insurance) ☐Workman's Compensation
☐Medicare ☐Personal Injury (attorney) ☐Automobile Insurance Policy (MedPay)
☐Check, Credit Card and/or Cash

Name of Primary Insurance: _____

Who is the Policy Holder of Primary Insurance: **Patient ☐** **or** **Responsible Party ☐**

Name of Secondary Insurance Company (if any):_____

Who is the Policy Holder of Secondary Insurance: **Patient ☐** **or** **Responsible Party ☐**

Your E-mail address:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at our office? ☐ yes ☐ no
If yes can we have the name of your Family Medical Doctor:_____

UNIVERSITY CHIROPRACTIC AND WELLNESS

CURRENT COMPLAINT HISTORY

PATIENT'S NAME:_____

1. What is your Major Complaint (symptom, or reason for visit)?_____
2. Is this the first time you've ever had this problem? □ Yes □ No
   If yes, when did it start? _____
   If no when was the first time you had it? _____ And how did it occur originally? _____
3. Is this episode the result of a □ **Injury** □ **Car Accident** □ **Work Injury** □ **None of the preceding**
4. Have your symptoms become worse since they started? □ Yes □ No
5. How frequent are the symptoms—> □ **Constant (24/7) or** □ **Come & Go**

6. Describe the pain □ Sharp □ Aching □ Burning □ Stabbing □ Dull □ Numbness □ Tingling □ Other:

7. Are there any other symptoms you are having that may or may not be related to the above problem? _____

_____

8. Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

9. Have you been treated for a health condition by a physician in the past year? □ Yes □ No If yes, describe. _____

_____

10. Do you have difficulty falling asleep? Or staying asleep? □ Yes

11. Do you feel stressed or suffer from anxiety? □ Yes

12. Do you have significant pain in multiple joints? □ Yes

13. Do you have migraine headaches? □ Yes

14. For women only. Are you pregnant or is there a possibility that you are pregnant? □ Yes □ No

13. Have you ever been diagnosed as having or have suffered from? (Check below if different that above)

__ Broken or Fractured Bones	__Osteoarthritis	—Eating Disorder	—High/Low Blood Pressure
_ Circulatory Problems	__Epilepsy	__ Alcoholism	__Coughing Blood
_ Rheumatoid Arthritis	__Pace Maker	__ Drug Addiction	__Ulcers
_ Seizures/Convulsions	__Strokes	__ HIV Positive	__Excessive Bleeding
_ Congenital Disease	__Cancer	__ Gall Bladder	__Depression

List any medications you are taking: _____ _____

_____/_____/_____
Patient's Signature Date

_____

_____

_____

UNIVERSITY CHIROPRACTIC AND WELLNESS

INSURANCE AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

PRIVACY NOTICE

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

RECORDS RELEASE AUTHORITY

I, _____, hereby request that _____ provide:
_____a copy of the report for my MRI/CT scan and/or any other radiological tests
_____a copy of all my medical notes pertinent to the treatment of my _____ to

Dr. Matthew S. Hitchner at University Chiropractic and Wellness.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

NO-SHOW APPOINTMENT POLICY

We work hard to see patients on time. If you are unable to keep your appointment, please call us 12 hours in advance if you need to reschedule or cancel your appointment so we can offer the time reserved for you to someone else who needs it. Generally, we cannot fill appointment spots with less than 12 hours notice. We will charge a $25 missed appointment fee for missed or cancelled appointments with less than 12 hours notice.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____