PLEASANT VALLEY CHIROPRACTIC

7664 Broadview Rd. Parma, OH 44134
PH: 216-520-6880 ~ Fax 216-520-6885

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home/Cell Phone: _____

City: _____ Zip: _____ Work: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID #: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Employer: _____

Secondary Insurance: _____ Ins. Phone#: _____

Group # _____ ID#: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Pleasant Valley Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

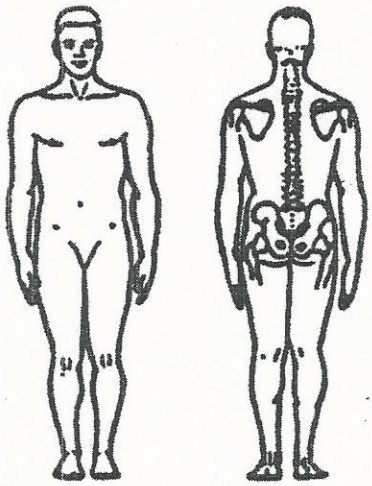
_____ _____

Signature of Insured / Guardian Date

Name:

Date:

Please describe your major problems and mark the exact location of your pain on the diagram below.



Place an "X" on the line below which would best describe the degree of your pain.

NO PAIN |——————————| PAIN WORST IT CAN BE

When did you first start having these symptoms? _____

What may have caused these symptoms? (Example: fall, accident, lifting, etc.) _____

Have you ever had these symptoms before? ❑ Yes ❑ No If Yes, please explain: _____

Have you ever received treatment for this condition before? ❑ Yes ❑ No If Yes, please explain: _____

Any Chiropractic care in the past? ❑ Yes ❑ No Name: _____ Date: _____

Pains are: ❑ Sharp ❑ Dull ❑ Constant ❑ Intermittent

What lessens your condition/pain? _____

What aggravates your condition/pain? _____

Has this problem been: ❑ Getting Worse ❑ Getting Better ❑ Staying the Same

Past medical diagnosis of your complaint, if any: _____

Briefly describe what surgery, if any, has been done: _____

Medication you now take: ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxers ❑ Pep Pills ❑ Insulin

❑ Birth Control Pills ❑ Tranquilizers ❑ Other (Please list.) _____

Have you ever had an automobile accident? ❑ Yes ❑ No Approximate Dates: _____

Medical History (Please check any of the following relevant to your medical history.)

❑ Cancer	❑ Hepatitis	❑ Dizziness	❑ Rheumatic Fever	❑ Backaches
❑ Polio	❑ German Measles	❑ Arthritis	❑ Scarlet Fever	❑ Numbness
❑ Tuberculosis	❑ Venereal Disease	❑ Neuritis	❑ Nervousness	❑ Anemia
❑ High Blood Pressure	❑ Muscular Dystrophy	❑ Rheumatism	❑ Asthma	
❑ Heart Trouble	❑ Multiple Sclerosis	❑ Epilepsy	❑ Digestive Disorders	
❑ Diabetes	❑ Convulsions	❑ Concussion	❑ Sinus Trouble	

UPDATE PATIENT INFORMATION

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Height: _____feet_____inches

Weight: _____lbs

BP: _____/_____ L/R

Race?

- ☐ I do not wish to provide
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other_____

Ethnicity?

- ☐ I do not wish to provide
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other_____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes, What? _____

Are you currently taking any prescribed medications?

- ☐ Not currently prescribed any medications
- ☐ Yes

What? _____ _____mg

What? _____ _____mg

What? _____ _____mg

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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Pleasant Valley Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and **(give my permission / don't give permission)** to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____