HEALTHCARE CHIROPRACTIC & Rehabilitation Clinic

Patient #_____
Doctor _____

New Patient Information

ABOUT YOU:

Name: _____ Social Security #: _____ Marital: S M W D

Date of Birth: _____ Age: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____ Preferred: H W C

Employer Name: _____ Employer Ph: _____ Occupation: _____

How many children do you have? ____ Whom may we thank for referring you? _____

Have you ever seen a Chiropractor? Yes or No, If yes, when? _____

ABOUT YOUR FAMILY:

Name of Spouse (or parent if minor): _____

Work Ph: _____ Cell Ph: _____

Spouse Employer: _____ Address: _____

Name of Nearest Relative: _____

Address: _____ Home Ph: _____

YOUR CONDITION:

Purpose of this appointment/current problem: _____

Other doctors seen for this condition: _____

Is the condition due to injury or sickness arising out of employment or auto accident? Yes or No

Date symptoms appeared or accident happened: _____ Days lost from work: Yes or No, How many? _____

Do you suffer from:

☐ Dizziness	☐ Neck Pain	☐ Shoulder/Arm Pain	☐ Nervousness
☐ Back Pain	☐ Arthritis	☐ Hip/Leg Pain	☐ Sinus Trouble
☐ Heart Trouble	☐ Headaches	☐ Urinary Problems	☐ Male/Female Troubles
☐ Diabetes	☐ Numbness	☐ Digestive Disorders	☐ Cancer

Do you smoke? Yes or No, How many packs/day? _____ Do you have a pacemaker? Yes or No

Have you been treated for any health conditions by a physician in the last year: Yes or No

If Yes, then describe: _____

Date of last physical examination: _____ List surgeries: _____

Serious illnesses: _____

What vitamins/medications are you taking? _____

If female, are you preganant? Yes or No Are you taking birth control? Yes or No

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(s). 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 doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual percentage rate of 16%.

RELEASE OF INFORMATION: By signing this form, you are granting consent to *Health*CARE CHIROPRACTIC & Rehabilitation Clinic to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

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. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____

Patient or Guardian Signature Authorizing Care Date

Symptom Explanation

1. List all symptoms, starting from the worst to least. _____

_____

2. When was the first time you noticed this problem? _____

a. How did it occur? _____

b. Has it become worse recently? Yes or No If yes, when and how? _____

_____

3. How frequent is the condition? _____

a. How long does it last? _____

4. Have you ever had the same or similiar condition: Yes or No If yes, when? _____

Describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom? Yes or No, If yes, describe: _____

_____

6. If pain is involved, is it:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Other _____
☐ Aching ☐ Burning ☐ Tingling ☐ Shooting

7. Is there anything you can do which seems to provide relief? Yes or No, If yes, describe.

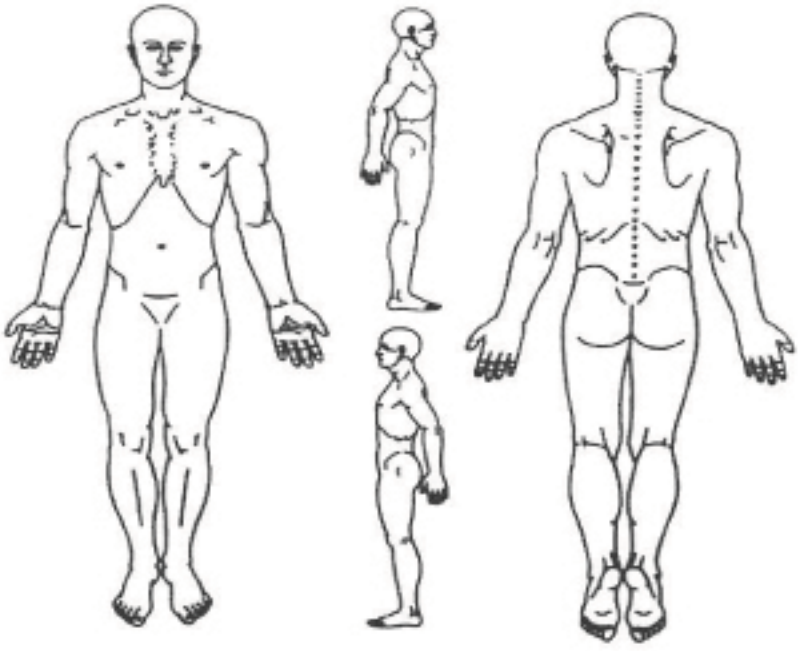
_____

8. What makes the problem worse? _____

9. List accidents, illnesses, surgeries, or broken bones. _____

_____

10. Please Circle Your Symptom Areas



11. Rate the Severity of Your Condition

10 out of 10

9 out of 10
(Stops all activity)

8 out of 10

7 out of 10

6 out of 10
(Stops some activity)

5 out of 10

4 out of 10

3 out of 10
(Forgotten with activity)

2 out of 10

1 out of 10

O out of 10
(None)

Welcome! We are excited to serve your health care needs in an effective and efficient manner. You can always check out our web page for more information about the office and office events at www.healthcarechiropractic.net.

Please select times that would work best for your follow-up visits. Please circle all that might apply for any 3 days:

Monday:	**Early Morning**	**Late Morning**
	Early Afternoon	**Late Afternoon**
Tuesday:	**Early Morning**	**Late Morning**
	Early Afternoon	**Late Afternoon**
Wednesday:	**Early Morning**	**Late Morning**
	Early Afternoon	**Late Afternoon**
Thursday:	**Early Morning**	**Late Morning**
	Early Afternoon	**Late Afternoon**
Friday:	**Early Morning**	**Late Morning**
	Early Afternoon	**Late Afternoon**

Clincial Hours are:

Monday-Friday 10 am - 1 pm, 3 pm - 6 pm

When it comes to your health, we believe medical doctors and chiropractors should work together for Your benefit.

Dr. Bedford agrees! I give you permission to inform my personal medical doctor of my condition, treatment, and expected/actual response to care at this office.

Signature of Patient or Guardian:_____ **Date:**_____

Please print your name: _____

Your Medical Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____

Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient Name:_____ **Patient ID#:**_____

Insured's Name:_____ **Insured's Date of Birth:**_____

Insured's ID#:_____ **Claim# (if applicable):**_____

Insured's SSN#:_____ **Insured's Group#:**_____

I hereby instruct and direct _____ **Insurance Company to pay by check, made out to and mailed directly to:**

*HEALTH*CARE CHIROPRACTIC & Rehabilitation Clinic, P.A.
Dr. Robert Bedford
2625 Old Denton Road, Suite 314
Carrollton, TX 75007-5113
www.healthcarechiropractic.net
(214) 483-3300
(866) 751-7418

If my current policy prohibits direct payment to my doctor, then I hereby instruct and direct you to make the check payable to me and mail it to:

*HEALTH*CARE CHIROPRACTIC & Rehabilitation Clinic, P.A.
Dr. Robert Bedford
2625 Old Denton Road, Suite 314
Carrollton, TX 75007-5113
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for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGMENT OF MY RIGHTS, TITLES INTERESTS, AND BENEFITS TO THIS OFFICE UNDER THE POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, and balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Dated this _____ **day of** _____ **, 20** _____

Signature of Insured and or Claimant_____

Signature of Witness_____