Patient Name:_____ Date:_____

Allergies

Yes	No	Allergy
		Acetaminophen
		Aspirin
		Chromium
		Dairy products
		Dust mites
		Eggs
		Mold
		NSAID's
		Peanuts
		Pet dander
		Poison ivy
		Pollen
		Seasonal allergies
		Shellfish
		Smoke
		Venom-bee/wasp
		Wheat

Past Medical History

Yes	No	Condition
		Arm pain
		Arteriosclerosis
		Arthritis
		Back pain
		Bad work conditions
		Bursitis
		Cancer
		Car accident
		Chest pain
		Diabetes
		Difficulty breathing
		Digestive problems
		Dizziness
		Headaches
		High blood pressure
		Leg pain
		Menstrual problems
		Nervousness
		Neuritis
		Numbness
		Rheumatic heart disease
		Ruptured disc
		Scoliosis
		Sinus conditions
		Stroke
		Ulcers

Additional Information

What Nutritional Supplements are you taking?

_____
_____
_____
_____
_____

What Prescription Drugs are you taking?

_____
_____
_____
_____
_____

What Over-The-Counter Drugs are you taking?

_____
_____
_____
_____
_____

Are you interested in Wellness Care (improving your overall health) or Symptomatic, first-aid care only?

Please Check One

☐ Wellness Care

☐ Symptomatic, First-Aid Care

Family History

Yes	No	Disorder	Details
		Arthritis	Who in your Family Had? (Circle All That Apply) Mother Father Sister Brother
			Type of Arthritis? (Circle All That Apply) Rheumatoid, Osteoarthritis, Ankylosing Spondylitis, Psoriatic, Reiters
		Cancer	Who in your Family Had? (Circle All That Apply) Mother Father Sister Brother
			Type of Cancer? (Please list)
		Diabetes	Who in your Family Had? (Circle All That Apply) Mother Father Sister Brother
			Which Type Do You Have? (Circle One) Type I Type II
		Heart Problems	Who in your Family Had? (Circle All That Apply) Mother Father Sister Brother
		Stroke	Who in your Family Had? (Circle All That Apply) Mother Father Sister Brother

Social History

Yes	No	Condition	How much used?	How long used?
		Alcohol use		
		Caffeine use		
		Chemical contacts		
		Tobacco use		

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our polices and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient **Date**

Personal

Patient Name:_____
Address:_____
City/State/Zip:_____
Social Security #:_____
Gender: [F] or [M] *Marital Status:*_____
*Spouse's Name:*_____
Patient's Birthdate:___/___/___ Age:_____
Home Phone:_____
Work Phone:_____Ext:_____
May we contact you at work? Yes or No
Cell Phone _____
*E-mail:*_____

Send Statement: c/o_____
Address:_____
City/State/Zip:_____
Phone:_____ Relation:_____

Emergency Contact:_____
Phone:_____ Relation:_____

How were you referred?_____
Employer:_____

History

Were you in an Auto Accident?_____
Is this a Work Related Injury?_____

Will you be utilizing medical benefits?circle one
NO Insurance Insurance Auto/Acc Ins Medicare
Work Comp HSA Health Fund

Daily Activity/Occupation:

My purpose for this appointment:_____
_____
Date symptoms appeared:_____
Ever had the same or similar condition? Y or N

What surgeries or serious illnesses have you had?(include dates)_____
_____
_____Have you been treated for any health condition by a physician in the last year? _____
Name of Physician _____
Phone:_____
Medications/drugs you are taking:_____
_____

Guarantor

Policy Holder:_____
Address:_____
City/State/Zip:_____
Social Security #:_____
Gender: [F] or [M] Birthdate:___/___/___

Employer:_____
Address:_____
City/State/Zip:_____
Work Phone:_____Ext:_____

Patient is: [self] [spouse] [child] [3rd party]
Other:

Medicare ONLY
1.Do you or your spouse work for a company that provides you with health insurance? Y or N
2.Are you entitled to Medicare because of End Stage renal Disease? Y or N
3.Is the illness/injury the result of an accident or illness that occurred at work? Y or N
4.Is this illness or injury the result of an accident or other injury? Y or N
5.Has the treatment for this accident or illness been authorized by the Veterans Administration? Y or N
6.Are you entitled to any benefits under the Federal Black Lung Program? Y or N
7.Do you have a Medicare Medigap Policy? Y or N
8.Do you have a Medicare Supplement Policy? Y or N
(provided by employer you retired from.)

Please Initial

_____ **YES** I will pay my portion at the time of service.
_____ **YES** This office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay any claims. I authorize payment directly to: Robertson Chiropractic Center of the "Health Benefits", "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly. 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, any fees for professional services will be immediately due and payable.

X_____ ___/____/____

Patient/Guarantor's Signature Date

RCC
Robertson Chiropractic Center

209 North Main
McPherson KS 67460
(620) 241-2025