CLEGG CHIROPRACTIC

~WELCOME~

Today's Date____________________

ABOUT YOU:

Patient name____ Nickname_______________

Last First M

Birthdate____/____/_____ Age______ Social Security #____________________ [ ] Male [ ] Female

MM/DD/YYYY

Mailing Address____

City _____________________________ State _______ Zip____________

Mobile Phone #________________________ Secondary Phone #________________________

E-mail address_____________________________ Referred by_____________________

Status [ ] minor [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

Spouse's name_________________________

Emergency contact____________________________ Contact number_________________

INSURANCE INFORMATION:

Primary's name_______________________________Relation____________DOB____________

Primary's Employer__________________________ How long________ Occupation_______________

Secondary Insurance_____________________________

REASON FOR VISIT:

The reason for this visit is a result of [ ] work [ ] sports [ ] auto [ ] trauma [ ] chronic

Explain what happened____

Describe pain and location____

When did the condition begin? _____/_____/________

Is condition getting worse? [ ] yes [ ] no [ ] constant [ ] comes and goes

Is this condition interfering with your [ ] work [ ] sleep [ ] daily routine

If so, please explain____

Have you had this or similar conditions in the past? [ ] yes [ ]no

If so, please explain____

Have you been treated by a Medical Physician for this condition? [ ] yes [ ]no

If so, where? _________________________

Have you been treated by a chiropractor before? [ ] yes [ ] no If so, whom?_________________

HEALTH HISTORY:

List any medications you are currently taking:____

____

Do you have any of the following diseases or conditions?

Y N Heart attack/stroke	Y N Heart Surgery/pacemaker	Y N Heart murmur
Y N Congenital Heart defect	Y N Mitral valve prolapse	Y N Artificial valves
Y N Alcohol/drug abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/low blood pressure	Y N Psychiatric problems	Y N Rheumatic Fever
Y N Severe/frequent headaches	Y N Kidney problems	Y N Ulcers/colitis
Y N Fainting/seizures/epilepsy	Y N Sinus problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty breathing	Y N Chemotherapy
Y N Lower back problems	Y N Artificial bones/joints	Y N Arthritis

List any other serious medical conditions____

____

Previous surgeries/treatments with dates____

Past serious accidents with dates____

Allergies_______________________________

Family health history____

*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for alll services rendered at the time of visit, unless other arrangements have been made with management. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____________________________________ _________________________________

Signature Date

Cancellation/No Show Policy

If it is necessary to cancel your scheduled appointment,
we require that you call or leave a message at least 24 hours prior to your appointment time.
Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely care.

We reserve the right to charge a $25 fee for any scheduled visits that are:

Cancelled with less than 24 hours notice
Are missed without calling to cancel (no-show)

You are required to pay the cancellation fee prior to the start of your next visit.
Cancellation fees cannot be billed to insurance.

____________________	____________________	______________
Patient Name	Signature	Date

HIPAA MEDICAL RELEASE FORM

I, _________________________, **authorize** OR **do <u>not</u> authorize** (please circle) Clegg Chiropractic to release my medical records to the following:

_____ Other medical practitioners

_____ Individual/s

Name: ____

Name: ____

Redisclosure: I understand that Clegg Chiropractic cannot guarantee that the recipient/s listed above will not redisclose my health information to a third party. The third party may not be required to abide by this contract or applicable to federal and state law governing the use and disclosure of my health information.

____

PRINTED NAME | SIGNATURE | DATE

If patient is unable to sign or is a minor, please complete the information below

____

NAME OF GUARDIAN /REPRESENTATIVE | SIGNATURE | DATE