

PATIENT INFORMATION

DATE: _____

Name: _____ DOB: _____ Sex: M F

Social Security Number: (required) _____

Address: _____ City _____ State/Zip _____

Primary Phone: _____ Cell: _____ E-mail _____

Race: Non-Hispanic/Hispanic Ethnicity: _____ Preferred Language: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Marital Status: S M D W

Patient Employer: _____ Address: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer: _____ Address: _____

Spouse's Employer Phone Number: _____

INSURANCE

Primary: _____ ID# _____ Group# _____

Medicare: Y N

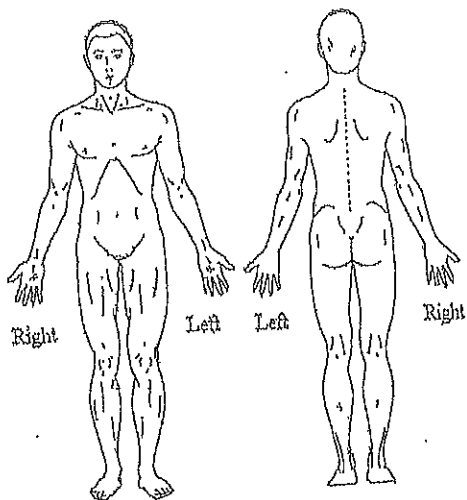
Secondary: _____ ID# _____

Reason for Seeking Care:

Injury or Accident: Y N If accident, what type: Work/ Auto/ Lifting/ Other _____

Date of Accident: _____

How did you hear of us? _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

- | | |
|----------------|-----|
| Numbness | === |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | /// |
| Pins, Needles | +++ |
| Other _____ | ^^^ |

Is this condition worse during certain times of day? Yes No
 Is this condition interfering with Work Sleep Routine
 Other _____
 Is this condition progressively getting worse Yes No

What activities aggravate your condition/pain _____

What activities lessen your condition/pain? _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

HEALTH HISTORY:

Primary Physician (MD, DO, NP, PA): _____

Primary Physician Phone Number: _____

Current Medications/Supplements (If you have list, please give to staff to copy and no need to fill this out) _____

Allergies: _____ Latex Sensitivity: Y N Shellfish: Y N
What type of allergic reaction to you experience: Rash Hives Headaches Other: _____

Past Surgeries: _____

Have you ever had X-rays, MRI's, CT scans?

If so, where and when and of what area: _____

Family History:

Father: _____ Mother: _____

Siblings: _____

Smoker or tobacco use: Y N How many packs/day: _____

Alcohol Use: Y N Drinks per day _____ week _____ Occasionally _____

Smith Chiropractic Clinic
14015 Jamestown Road
Breeze, IL 62230
618.526.7732

Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic.

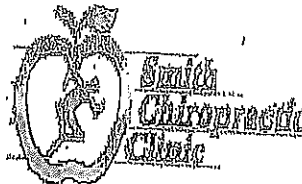
I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, dislocations, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____



HIPPA Privacy Notice

I have read and understand the HIPPA Privacy Notice provided to me by this office.

I also understand that I may revoke any previous authorization and or consent, in writing, at any time.

Signature: _____

Date: _____

Smith Chiropractic & Sports Medicine Clinic
Dr. Clinton M. Smith
14015 Jarnestown Road
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Assignment, Lien and Authorization Insurance Benefits and Attorney

Authorization Statement

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Dr. Clinton M. Smith such sums as may be due and owing to this office for services provided to me, both by reason of accident or illness, and by reason of any benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me for any settlement, judgement or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to this office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by this office. This is to act as an assignment of my rights and benefits to the extent of the offices; services provided.

In the event that my insurance company refuses to pay this office for services the office provided me pursuant to its contractual obligation, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute this cause of action either in my name or in the office's name and further I authorize this office to compromise, settle or otherwise resolve this claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services, including any fees and costs incurred should my account be placed with a collection agency or with an attorney's office. Collection costs are \$20.00 per occurrence. Legal costs include the lawyer's hourly rate of \$250.00 plus cost of the suit including filing and service of process fees. I further understand and agree that this assignment, lien and authorization does not constitute any consideration for this office to await payments and this office may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case and to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above-mentioned office given power of attorney to endorse/sign my name and all checks for payment of my doctor bill.

Signature: _____

Date: _____

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Please read carefully before signing and check one section that applies.

_____ Group or Individual Insurance: when possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Furthermore, knowledge of insurance coverage is ultimately your responsibility. Payment will be due by you at the time of service for any noncovered services, deductibles or co-pays. We are happy to accept cash check or credit card.

Name of insurance company: _____

_____ Out-of-network insurance: you will receive our discounted rate for payment at the time of service and we will give you receipts to turn into your insurance yourself you may choose to have us submit your insurance. Payment will be due by you at the time of service for any noncovered services, deductibles or co-pays. We are happy to accept cash check or credit card.

_____ Patients without insurance: You will receive discounted fees for services rendered. All fees must be paid on each service date. We are happy to accept cash, check or credit card.

_____ "On the Job" Injury (Worker's Compensation): If you are injured on the job, your care should be paid for under your employer's workers compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. We will also call your employer to verify the claim. If your employer does not provide us with that information and/or you terminate or suspend care, all fees and services are due immediately. If your Worker's Compensation claim is denied or your award is less than the amount due, you remain responsible for all outstanding fees.

_____ Personal Injury or Automobile Accidents: Please notify your auto insurance carrier of your visit to our office. Notify our insurance department immediately if an attorney is representing you. You are responsible for all fees upon settlement or award following a lawsuit. If your settlement or judgment does not cover the full amount of your fees or is completely denied, you remain responsible for all outstanding fees.

I understand I will be held responsible for any fees and costs incurred should my account be placed with the collection agency or attorney's office. We assess a \$20 collection fee for cases not pursued by an attorney, irrespective of the amount owed. All debts that are handled by our attorney are subject to full attorney fees. We reserve the right to pursue collections for the applicable statute of limitations.

Signature of Patient (or Guardian, if patient is a minor)

Date: _____

Signature of Office Representative

Date: _____

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