Smith Chiropractic
AND OCCUPATIONAL MEDICINE

Dr. Clinton M. Smith
14015 Jamestown Road
Breese, IL 62230
Office: (618) 526-7732
Fax: (618) 526-8312

PATIENT INFORMATION

Date: _____

Name: _____ DOB: _____ Sex: M F

Social Security Number **(required):** _____

Address, City, State, Zip: _____

Phone: _____ **Cell Phone:** _____ **Email:** _____

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

Emergency Contact: _____ **Phone**: _____ Relationship: _____

Marital Status: S M D W

Patient's Employer: _____ Address: _____ **Phone**: _____

Spouse's Name: _____ Spouse's Phone: _____

Spouse's Employer: _____ Address: _____

INSURANCE:

Primary: _____ ID #: _____ Group #: _____

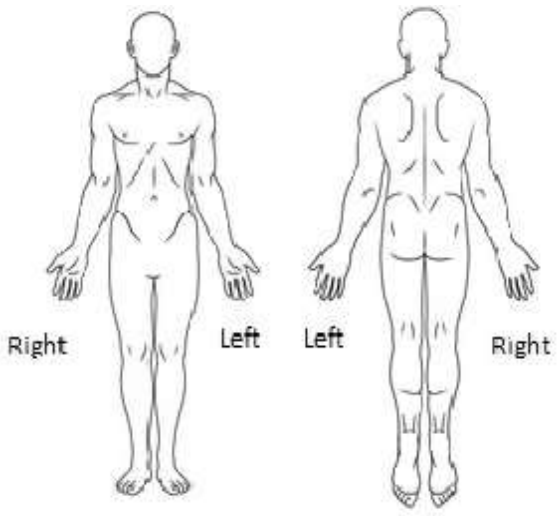
Medicare: Y N

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-no pain to 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 the 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

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HEALTH HISTORY:

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

Primary Physician's Phone Number: _____

Current Medical Conditions (ex.: Diabetes, Pace Maker, etc.): _____

_____

Current Medications/Supplements (If you have a list, please give to staff to copy; otherwise, list medications below): _____

_____

Allergies: _____ Latex Sensitivity: Y N (Please circle) Shellfish Sensitivity: Y N (Please circle)

What type of allergic reaction do you experience (i.e., rash, hives, headaches, etc.): _____

_____

Past Surgeries: _____

_____

Have you ever had X-rays, MRIs, CT scans? Y N

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

_____

Smoker or Tobacco Usage: Y N Specify: _____ How many packs/day: _____

Alcohol Use: Y N Drinks per day: _____ per week: _____ or occasionally: _____

FAMILY HEALTH HISTORY (CANCER, HEART DISEASE, ETC):

Father: _____ Mother: _____

Siblings: _____

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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, disc injuries, 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: _____

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HIPAA Privacy Notice

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

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

Signature: _____ Date: _____

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HIPAA COMPLIANT RELEASE TO TALK TO OTHERS

Due to the HIPAA Act, we are not allowed to speak with anyone in regard to you treatment and/or financial obligations with Smith Chiropractic unless we have your signed consent.

_____ _____
Patient's printed name Date of Birth

The individuals listed below are allowed to receive my treatment and/or financial obligation information with regard to services performed by Smith Chiropractic and Sports Medicine Clinic:

_____ _____ _____
Name of person Relationship Telephone number

_____ _____ _____
Name of person Relationship Telephone number

It is okay to leave a message on my home and/or cell phone: ____Yes ____No

_____ _____
Signature of patient/responsible party Date

PLEASE DO NOT SIGN THIS NOW.
This notice can be rescinded at any time in the future by signing the date you want it rescinded. Only sign this when you want to change and/or delete the names above.

_____ _____
Patient signature Date

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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 and 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 office's 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 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 the 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 to 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 their insurance carrier. We will also call your employer to verify the claim. If your employer does not provide us with the 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: _____