

North County Pain Relief Center - Chiropractic Physician
7157 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4201

Confidential Patient Health Record

Date _____

Patient Information

Last: _____ First: _____ Middle: _____

Birth Date: ___/___/___ Age: _____ Sex: Male Female Social Security # _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ - _____ Second Phone: (_____) _____ - _____

Email Address: _____

Legal Guardian Information - if patient is a minor (under 18)

First Name: _____ Last: _____ Relationship: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ - _____ Second Phone: (_____) _____ - _____

Email Address: _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Best Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Ext _____

Employment Information

Business Name: _____

Describe Job Activities: _____

BEFORE YOUR INJURY, were you experiencing any of the following symptoms/problems?

back or neck pain headaches tingling in arm/hand tingling in leg/foot pain in arm or leg

Have you seen a doctor for any of the previous listed health problems? No Yes When? _____

Dr.'s Name: _____ Type of treatment: _____

Have you **PREVIOUSLY** been treated for injuries due to an auto collision? No Yes When? _____

Adult Illnesses: CHECK all health conditions. CIRCLE IF IT IS CURRENT

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> lung problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> lupus | <input type="checkbox"/> seizures |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> strokes |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> liver disease | <input type="checkbox"/> Other _____ | |

Patient Name _____ Date _____

Current Medications: List all medications you are currently taking.

Medication	For What Condition?	Medication	For What Condition?

Surgery (ies): List all surgical procedures.

Surgery	Date	Surgery	Date

Injury (ies): Mark the injuries you have had **BEFORE** this one.

- back injury
- broken bones
- disability (ies)
- fall (severe)
- head injury
- joint injury
- motor vehicle accident
- sports injury
- work accident

Your Auto Insurance OR for the vehicle you were in

Date Of Accident: ____/____/____ Time: _____ Where did accident happen? Missouri Illinois Other _____

Did the police come? No Yes Did you report the accident/injury to your insurance company? No Yes

Name of Policy Holder: _____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Person Who Hit You - Insurance

Person's Name: _____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Signature of parent or legal guardian if patient is under 18 years old.

Guardian Print Name: _____ Date: _____

Guardian's Signature: _____ Date: _____

Patient: _____ Age: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandards/Downloads/securityproposedrule.pdf>.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This includes the named attorney of record representing you. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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 their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. A patient has the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial: Patient _____ OR Parent or Legal Guardian _____

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

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, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial: Patient _____ OR Parent or Legal Guardian _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial: Patient _____ OR Parent or Legal Guardian _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred. This includes release of medical & financial information to the patient's attorney.

Initial: Patient _____ OR Parent or Legal Guardian _____

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

Initial: Patient _____ OR Parent or Legal Guardian _____

Patient's Signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____

Patient Name _____

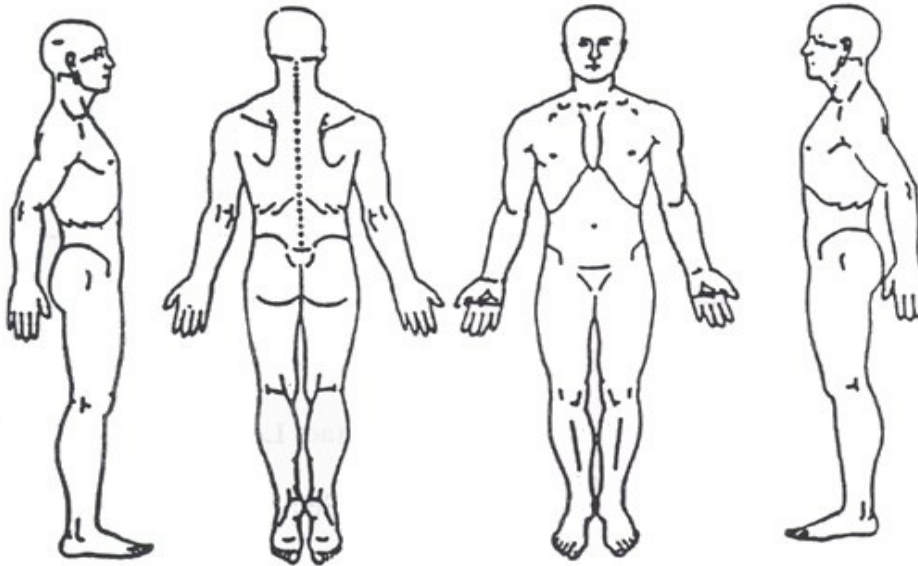
Today's Date ____/____/____

INJURY HISTORY

Date of Injury ____/____/____

Time of Injury _____

Please mark the area of your pain or discomfort:



1. Is your condition currently... worsening improving unchanged?
2. Is your condition worse in the: Morning Afternoon Night With Activity

Circle any of the following you have experienced since your injury			
Mood swings	Depression	Sensitive to sound	Dizziness
Confusion	Concentration Difficulties	Nausea	Balance problems
Ringing in the ears	Sensitive to light	Vomiting	Blurred Vision

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Patient Name: _____

The next form is a request for medical records. If you have sought medical care of any kind for your injury, we need your permission to obtain a copy of those medical records.

Please sign the next form but leave the Doctor/Hospital information blank.

List below the urgent care, hospital(s) and/or doctor(s) that you have seen.

Urgent Care: _____ **Were X-rays taken? Y N**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **When did you go?:** _____

Hospital: _____ **Were X-rays taken? Y N**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **When did you go?:** _____

Doctor: _____ **Were X-rays taken? Y N**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **When did you go?:** _____

Doctor: _____ **Were X-rays taken? Y N**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **When did you go?:** _____

