New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name _____ Last Name _____ Date _____ Email* _____

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (Work) _____ (home) _____ Referred By _____

Age _____ Birth Date _____ Social Security # _____ Number of Children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Health Status _____

Emergency Contact _____ Phone _____

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe: _____

Date of Injury _____ Date symptoms appeared _____

Have you ever had same condition? ○ No ○ Yes If yes, when? _____

List of other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ○ No ○ Yes Name of company _____

*** If an auto accident, please provide:**

Insurance Company Name _____ Contact Person _____

Phone: _____ Claim # _____

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)l

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes
What activities aggravate your symptoms?	○ No	○ Yes

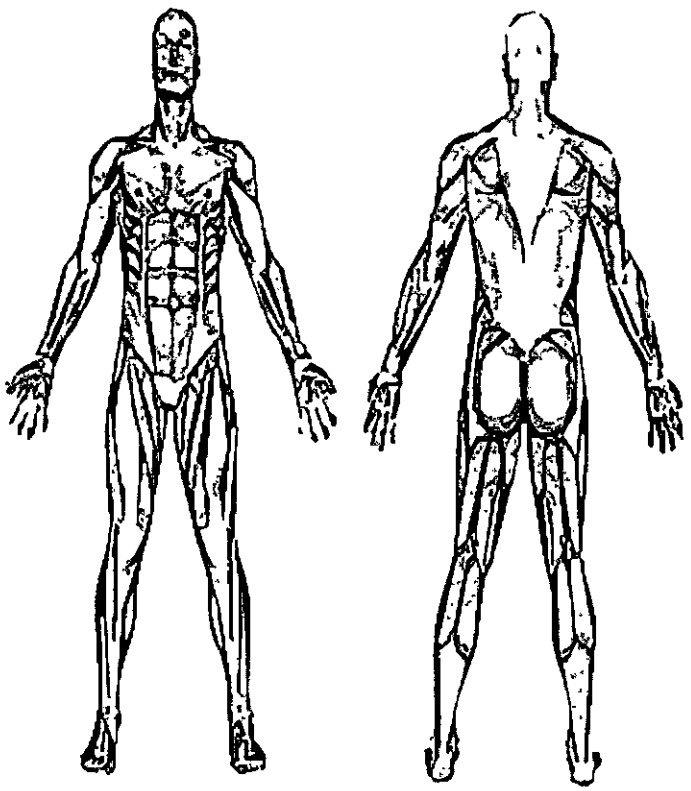
Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

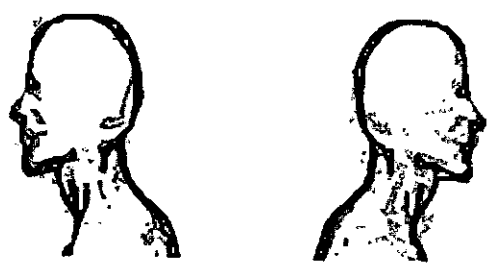
Have you ever suffered from:

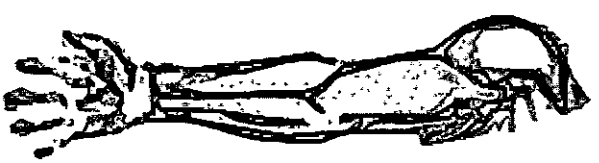
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing







Precise Chiropractic & Rehabilitation
2191 Defense Highway, Suite 222
Crofton, Maryland 21114
(410) 370-0600

Financial Policy

Precise Chiropractic & Rehabilitation is committed to providing you with the best possible care. We would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask if you have any questions regarding our fees, financial policy, or your financial responsibility.

We expect payment in full for all treatment at the time of service unless other arrangements have been made.

Health Insurance

If you have Health Insurance coverage, we will help you receive maximum benefits. Your insurance claim will only be completed and submitted if we are provided with all pertinent Health Insurance information. It is your responsibility to verify that your policy is enforce on your date of service. Otherwise, you are responsible for payment at the time of service. We will inform you if we are participating provider with your Health Insurance Company and will handle your claim according to our agreement with the insurance company. We will file insurance claims as a courtesy to you. We will not become involved in disputes between you and your Health Insurance Company regarding deductibles, co-payments, covered charges, secondary insurances, charges, etc., other than to supply necessary factual information to assist in processing your claim for Precise Chiropractic & Rehabilitation.

Deductibles and/or co-payments are required at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company within 30 days, the balance on the account becomes your responsibility. We will make every effort to resolve the claim before transferring the balance to you.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____, and assign directly to Precise Chiropractic & Rehabilitation all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my Health Insurance Company. I authorize the use of my signature on all insurance submissions for the treatment received at Precise Chiropractic & Rehabilitation.

Precise Chiropractic & Rehabilitation may use my health care information and may disclose such information to the above named Health Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for services.

Agreement

I have read and understood the information stated above, and understand that I am financially responsible for all charges whether or not paid by my insurance. Accounts carrying a balance over 30 days will be charged interest at a rate of 5% per month. If account is referred to collections or an attorney for collections, you will be charged a fee consisting of 25% of the outstanding balance at the time of collections.

Signature _____ Date _____

Witness Signature _____ Title _____

Date _____

HIPPA PRIVACY RECORDS

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

In the course of your care as a patient at Precise Chiropractic & Rehabilitation, we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, with your permission, may be disclosed to anther health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, HMO, PPO, or your employer (if they are or may be responsible for the payment of your services).
3. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, or to provide information about alternatives to your present care, or for other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine, as well as an email or text reminder may be sent. Further, you have the right to inspect or obtain a copy of the information we use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend that we provide care.

For additional information or questions regarding the HIPPA compliance, please visit: www.hhs.gov/ocr/hipps

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Precise Chiropractic & Rehabilitation Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

Signature: _____ **Date:** _____

____ Mark this box with an (X) if you are the patient's parent/ guardian/ Legal Representative. Sate your relationship below.

_____

Relationship to Patient

PRECISE

Chiropractic & Rehabilitation

APPOINTMENT CANCELLATION POLICY

Dear Valued Patient,

In order to ensure every patient receives proper focus and treatment, we have written this letter to address our practice's cancellation policy. As you may be aware, each appointment block allows for complete focus on you and the goals you are trying to achieve. These appointment slots are in high demand and sought after due to our individual attention. As a result of the factors previously listed, we require a **24-hour** cancellation policy prior to each appointment time. Late arrivals will still be seen but will conclude at the schedule time.

Cancellation of the appointment must be by phone or through our online appointment scheduling system.

There will be a $65 fee for any missed appointment or cancelation within 24 hours of the appointment.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date