

Willow Bend Chiropractic

5904 Chapel Hill Blvd. * Suite 210 * Plano, Texas 75093 * (972) 608-4411

Patient Information

Date _____

Name _____

Address _____
First M. Last Preferred Name

City _____ State _____ Zip _____

Sex: M F Birthdate ___/___/___ Age _____
 Single Married Widowed Separated Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse _____

Occupation _____

Whom may we thank for referring you?

Contact Information

Home Phone _____

Work Phone _____ Ext. _____

Other Phone _____

E-mail _____

IN CASE OF AN EMERGENCY, CONTACT:
Name _____

Phone _____

Insurance Information

Insured's Name _____

Insured's Birthdate ___/___/___

Relationship to Patient:
 Same Person Spouse Parent Other

Insurance Company _____

I.D./Policy # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above listed insurance company and assign directly to Willow Bend Chiropractic 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Patient Date

Accident Information

If Condition Due to an Accident

Accident Date _____

Type Of Accident: Auto Work Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

Attorney Phone _____

Patient Condition

Height _____ Weight _____

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse?
 Yes No Unknown

Rate the severity of your pain on a scale from 1 to 10
0-----5-----10
(no pain) (severe pain)

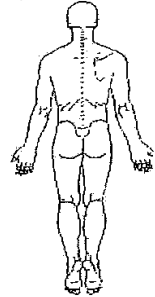
Type of Pain:
 Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramping Stiffness Swelling Other

How often do you have this pain (is it constant or does it come and go)? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark an X on the picture where you continue to have pain, numbness, or tingling



Additional Comments Concerning Your Condition:

Health History

What treatment have you already received for your condition? Chiropractic Services Medications Surgery
 Physical Therapy None Other _____

Name and telephone number of other doctor(s) who have treated you for your condition _____

Date of Last: Chiropractic Adjustment _____ Medical Appointment _____ Massage _____

Place a mark on "past", "present", or "never" to indicate if you have had any of the following:

<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy Shots <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anorexia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Appendicitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast Lump <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bulimia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pains <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fractures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> General Fatigue	<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gout <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herniated Disc <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lazy Eye <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Function <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mononucleosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful/Frequent Urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia	<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polio <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prosthesis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to Light <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tumors/Growths <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual Disturbance
--	--	--

Females Only

 Birth Control
 Painful Periods
 Hormonal Replacement
 Currently Pregnant
 Trying to Become Pregnant
 Miscarriage

Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):

Medications

Allergies

Vitamins

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

LIFESTYLE

- Smoking
- Alcohol
- Coffee/Caffeine
- Water

Packs/Day _____
 Drinks/Day _____
 Cups/Day _____
 Glasses/Day _____

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Willow Bend Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below I stat that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

 Patient Name

 Patient/Legal Guardian Signature

 Date

Willow Bend Chiropractic

5904 Chapel Hill Blvd. * Suite 210 * Plano, Texas 75093 * (972) 608-4411

Appointment Policy

For the most convenient appointment times for you, we ask that you please schedule your appointments in advance. It is also recommended for fast and complete healing that you keep your appointments when scheduled. The Doctor has spent time creating a specific treatment plan for your condition. When an appointment is missed, healing is delayed and the treatment plan is interfered with. If you should need to reschedule an existing appointment, please contact us prior to your appointment time so that we are better able to find a time that works for you. We ask that you please provide us with 24 hours notice for any appointment cancellations; this office reserves the right to charge \$30.00 for any missed, cancelled, or rescheduled appointments that do not meet these requirements. We understand that things come up and that you are busy, but please understand that we have most likely already told a patient that we have no appointments available for their treatment at that time.

Cell Phone Policy

As a courtesy to all patients, please silence and refrain from using your cell phones while in the office. If you should need to take a call, we ask that you please step outside until the call is complete. We thank you for your consideration in helping us to provide a completely relaxing atmosphere.

Fee Policy

Assignment of benefits for group insurance policies are accepted, and will be verified and discussed with you at the time of your first visit. Payment for services is due at the time of the office visit. Payment options include: cash, check, or credit card. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of \$15.00.

Acknowledgment of Office Policies

By signing below, I hereby acknowledge that I have read in full and understand the above mentioned office policies. I am also aware that the doctors, and/or staff, reserve the right to enforce these policies.

Printed Patient Name

Patient Signature

____ / ____ / ____
Date

Physician Reports

We have found that physicians, including pain management doctors and orthopedists, appreciate updated status reports and treatment notes for their patients. If you are currently seeing a physician who would like reports sent directly to their office, please list their information below:

Clinic Name: _____
Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

By signing below, I hereby acknowledge that my treatment information will be released in the form of physician reports to the above mentioned doctor and/or clinic.

Printed Patient Name

Patient Signature

____ / ____ / ____
Date

**WILLOW BEND CHIROPRACTIC'S HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION**

5904 Chapel Hill Blvd. Ste. 210
Plano, TX 75093
972.608.4411

By signing this form, I, _____, authorize the use and use disclosure of my health information as described below:

1. *Description of information:* Disclosure of my condition, prognosis, and treatment plan

2. *Name or class of person(s) or class of persons authorized to make the use or disclosure:* Employees and Authorized Agents of Willow Bend Chiropractic

3. *Name or identification of person(s) or class of persons authorized to receive the information (please list all family members, spouse name, friends or representatives that we may discuss your medical condition with):*

4. *Date or event when authorization expires:* This authorization does not expire unless:

5. *Description of each purpose of the requested use or disclosure:* Participation in the medical care of the patient or:

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Willow Bend Chiropractic at the address listed above.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

_____*[Initials of patient or guardian]* I understand that Willow Bend Chiropractic may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient or Guardian**

Date

Print Name of Patient

Print Name of Guardian

**If an individual's personal representative signs an authorization, the representative's authority is based on: _____ (e.g., state law, court order, etc.)