Willow Bend Chiropractic

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

Patient Information

Date______________

Name ______________________________________
First M. Last Preferred Name

Address ______________________________________

____
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

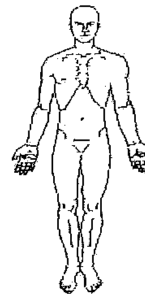
If Condition Due to an Accident
Accident Date ______________________________
Type Of Accident: ☐ Auto ☐ Work ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker's Comp ☐ Other
Attorney Name (if applicable)______________________
Attorney Phone ______________________________

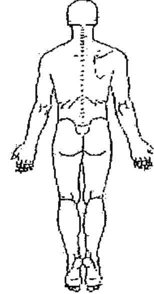
Patient Condition

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

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





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

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:

Past	Present	Never	Condition
☐	☐	☐	AIDS/HIV
☐	☐	☐	Abnormal Weight Gain
☐	☐	☐	Allergy Shots
☐	☐	☐	Anemia
☐	☐	☐	Angina
☐	☐	☐	Anorexia
☐	☐	☐	Appendicitis
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorders
☐	☐	☐	Breast Lump
☐	☐	☐	Bronchitis
☐	☐	☐	Bulimia
☐	☐	☐	Cancer
☐	☐	☐	Chest Pains
☐	☐	☐	Constipation or Diarrhea
☐	☐	☐	Diabetes
☐	☐	☐	Dizziness
☐	☐	☐	Emphysema
☐	☐	☐	Epilepsy
☐	☐	☐	Excessive Thirst
☐	☐	☐	Fractures
☐	☐	☐	General Fatigue

Past	Present	Never	Condition
☐	☐	☐	Glaucoma
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
☐	☐	☐	Hepatitis
☐	☐	☐	Hernia
☐	☐	☐	Herniated Disc
☐	☐	☐	High Blood Pressure
☐	☐	☐	High Cholesterol
☐	☐	☐	Kidney Disease
☐	☐	☐	Lazy Eye
☐	☐	☐	Liver Disease
☐	☐	☐	Loss of Bladder Function
☐	☐	☐	Migraine Headaches
☐	☐	☐	Mononucleosis
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Muscle Spasms
☐	☐	☐	Muscular Incoordination
☐	☐	☐	Osteoporosis
☐	☐	☐	Pacemaker
☐	☐	☐	Painful/Frequent Urination
☐	☐	☐	Parkinson’s Disease
☐	☐	☐	Pinched Nerve
☐	☐	☐	Pneumonia

Past	Present	Never	Condition
☐	☐	☐	Polio
☐	☐	☐	Poor Circulation
☐	☐	☐	Prostate Problems
☐	☐	☐	Prosthesis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Ringing in Ears
☐	☐	☐	Sensitivity to Light
☐	☐	☐	Stroke
☐	☐	☐	Thyroid Problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Tumors/Growths
☐	☐	☐	Ulcers
☐	☐	☐	Visual Disturbance

Females Only

Past	Present	Never	Condition
☐	☐	☐	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 — Packs/Day__________
☐ Alcohol — Drinks/Day__________
☐ Coffee/Caffeine — Cups/Day__________
☐ Water — 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 herby 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 polices.

_______________________________________ _______________________________________ ______ / _____/ ______

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 herby 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 or 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.)

Copyright 2004 Willow Bend Chiropractic HIPAA Authorization