Patient Information

Name: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip:_____ SSN: _____

Date of Birth :_____ Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell phone:_____

Email address: _____

Employer: _____ Work Phone:_____

Please describe your occupation: _____

Spouse Name: _____ Date of Birth: _____

Who referred you to our office? _____

Notify in case of emergency: _____ Phone: _____

Insurance Information

1.) Primary Insurance Company: _____

ID or Contract #: _____ Group#:_____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Phone:_____

2.) Secondary Insurance Company: _____

ID or Contract #: _____ Group #: _____

Subscriber's Name: _____ _____ Date of Birth:_____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Visit

Have you had chiropractic care before? ☐ Yes ☐ No If yes, where?_____

Are you coming to see us as a result of: ☐ An auto accident ☐ A work-related injury ☐ A personal injury

Please describe your symptoms: _____

_____

When did your symptoms start? _____

Have you had similar conditions in the past? _____

Other doctors seen for this condition: _____

Is your primary complaint worse in the: ☐ a.m. ☐ p.m. ☐ same

Is your pain worse when: ☐ Sitting ☐ Standing ☐ Lying down

What helps relieve your discomfort? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Nothing

PLEASE COMPLETE BOTH SIDES.

Please check any of the following conditions if you have ever experienced them:

☐ Headache	☐ Loss of balance	☐ High blood pressure	☐ Menstrual cramps & pain
☐ Shooting head pains	☐ Ringing in ears	☐ Low blood pressure	☐ Menstrual irregularity
☐ Sinus trouble	☐ Blurred vision	☐ Anemia	☐ Bladder irregularity
☐ Loss of smell	☐ Lights bother eyes	☐ Stomach trouble	☐ Bowel irregularity
☐ Allergies	☐ Neck pain	☐ Nerves/nervousness	☐ Diabetes
☐ Hayfever	☐ Muscle spasms in neck	☐ Inner tension	☐ Cancer
☐ Asthma	☐ Grinding in neck	☐ Irritability	☐ Sleeping problems
☐ Loss of taste	☐ Tightness of shoulders/arms	☐ Gallbladder trouble	☐ Painful joints
☐ Thyroid trouble	☐ Pain in shoulders/arms	☐ Indigestion	☐ Swollen joints
☐ Twitching of face	☐ Pins /needles in arms/hands	☐ Intestinal gas	☐ Pins & needles in legs
☐ Loss of memory	☐ Cold hands	☐ Low back pain	☐ Swollen ankles
☐ Fatigue	☐ Numbness in arms/hands	☐ Ulcers	☐ Cold feet
☐ Depression	☐ Shortness of breath	☐ Numbness in legs/feet	☐ Pains in legs/feet
☐ Dizziness	☐ Mid back pain	☐ Constipation	☐ Surgical Implants
☐ Fainting	☐ Heart attacks	☐ Kidney trouble	☐ Other_____

Have you ever had any falls, auto accidents, or injuries? ☐ Yes ☐ No If yes, please explain:

Month/Year:_____ Type of Accident:_____

Describe Injury: _____

Month/Year:_____ Type of Accident:_____

Describe Injury: _____

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain:

Month/Year: _____ Type of surgery: _____

Month/Year: _____ Type of surgery: _____

Are you presently taking medication or vitamins? ☐ Yes ☐ No If yes, please list:

Name of drug: _____ Name of drug: _____

Name of drug: _____ Name of drug: _____

Do you smoke? ☐ Yes ☐ No **Drink alcohol?** ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

What exercise programs do you currently participate in? _____

Family History

How many children do you have? _____ **Do any of your children have any of the following (list age):**

☐ Headaches	Age: _____	☐ Allergies	Age: _____	☐ Ear Infections	Age: _____
☐ Frequent Colds	Age: _____	☐ Asthma	Age: _____	☐ Constant Irritability	Age: _____
☐ Constipation	Age: _____	☐ Scoliosis	Age: _____	☐ Growing Pains	Age: _____
☐ Hyper Kinetic	Age: _____	☐ Bedwetting	Age: _____	☐ Nosebleeds	Age: _____

Do any of your blood relatives have any of the following (list relation to you):

☐ Diabetes	Relation: _____	☐ Cancer	Relation: _____
☐ Stroke	Relation: _____	☐ Heart Problems	Relation: _____
☐ Scoliosis	Relation: _____	☐ Back Problems	Relation: _____
☐ Headaches	Relation: _____	☐ Ulcers	Relation: _____

X _____ _____

Patient/Parent/Guardian Signature **Date**

DISCLOSURE & CONSENT for CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. David M. Purdy / Dr. Frank C. Miramonti / Dr. Michael Krauseneck / Dr. Timothy J. Murray, or by other licensed Doctors of Chiropractic serving as a backup for Dr. David M. Purdy / Dr. Frank C. Miramonti / Dr. Michael Krauseneck / Dr. Timothy J. Murray.

I have had the opportunity to discuss with Dr. David M. Purdy / Dr. Frank C. Miramonti / Dr. Michael Krauseneck / Dr. Timothy J. Murray, my diagnosis, the nature and purpose of chiropractic adjustments, and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative, if necessary e.g., if the patient is a minor or physically or legally incapacitated.

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship or authority of patient's representative

To be completed by doctor or staff

_____ _____
witness to patient's signature date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Purdy Chiropractic, PLC / Miramonti Chiropractic, PLLC / Krauseneck Chiropractic, PLC / Murray Chiropractic, INC's "Notice of Privacy Practices" has been provided to me. *

I understand I have a right to review Purdy Chiropractic, PLC / Miramonti Chiropractic, PLLC / Krauseneck Chiropractic, PLC / Murray Chiropractic INC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Purdy Chiropractic, PLC / Miramonti Chiropractic, PLLC / Krauseneck Chiropractic, PLC / Murray Chiropractic, INC. The Notice of Privacy Practices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Purdy Chiropractic, PLC / Miramonti Chiropractic, PLLC / Krauseneck Chiropractic, PLC / Murray Chiropractic, INC's duties with respect to my protected health information.

Purdy Chiropractic, PLC / Miramonti Chiropractic, PLLC / Krauseneck Chiropractic, PLC / Murray Chiropractic, INC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

*A copy of the Notice of Privacy Practices is available at the front desk. We will be happy to provide a copy for you to take home if you so desire.

OFFICE POLICY AND EXPLANATION OF COVERAGE

The following insurance and payment program allows you, our patient, to receive the care you need without the undue financial strain.

- It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. Our office will NOT enter into a dispute with your insurance company over your claim. Our office does NOT guarantee that your insurance will pay.
- Your insurance should pay within 30 days after billing. If your insurance company has not paid within 90 days, you must pay the balance due and be reimbursed by your insurance company, when and if it pays.
- A payment MUST be made each and every month there is an outstanding balance.

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to Dr. David M. Purdy / Dr. Frank C. Miramonti / Dr. Michael Krauseneck / Dr. Timothy J. Murray, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered to me. In the event my insurance is a reimbursing contract and I receive payment from my insurance carrier, I agree to bring in the checks and endorse them over to the clinic within one week of receipt. A photocopy of this assignment shall be considered as effective and valid as the original.

I agree to be financially responsible for all charges incurred at this office including, but not limited to, insurance deductibles, co-payments and any services rejected by my insurance company.

I have read the above provisions and hereby agree to abide by them as specified above.

_____ _____

Patient/Parent/Guardian Signature Date

FEMALE PATIENTS ONLY

VERIFICATION OF NON-PREGNANCY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone Number: _____ Date of Birth: _____

By my signature on this form, I do hereby state that, to the best of my knowledge I am not pregnant, neither suspected nor confirmed at this particular time.

Patient/Parent/Guardian Signature: _____

Doctor's Signature: _____

Witness Signature:_____