

PATIENT PERSONAL/CONFIDENTIAL DATA

Patient: _____ Date: _____
Home Address: _____ City: _____ Date of Birth: _____
Social Security No.: _____ Home Phone: _____ State: _____ Zip: _____
Employer: _____ Address: _____ Work/Cell: _____
Name of Spouse: _____ SS No.: _____ No. of Children: _____
Spouse's Employer: _____ Address: _____
How did you learn of this clinic? _____
Nearest relative not living with you? _____
Who is responsible for payment? () Self () Spouse () Other _____

Purpose of this visit & list your complaints: _____

Date of illness: _____ Time: _____ () AM () PM Location: _____

If Accident, please check one: () Auto () On the job () Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other doctor(s) seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? () Yes () No

If yes, please describe: _____

Insurance Information

I understand and agree that health & accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also authorize this clinic to release any information pertinent to my case to any insurance company, insurance regulatory agency, adjuster, and attorney involved in this case, and hereby release this clinic of any consequence thereof.

Assignment of Benefits

I hereby instruct & direct my insurance company/med-pay carrier/ third party payor or medical expense benefits allowable & otherwise payable to me under my current insurance policy to pay by check made out & mailed directly to Absolute Chiropractic, Inc. (Dr. Keith G. Ryan, D.C.) as payment towards the total charges for professional services rendered by this clinic. If I have an HMO (HMO's will only cover care that has been pre-authorized) I understand that if I do not have an authorization, or if the authorization for care is denied, then I agree to be personally & fully responsible for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original.

Consent of Professional Services

I hereby authorize and release the doctor and whomever he-she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case.

Patient Signature: _____ Date: _____

(if parent or guardian, please print name here) _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ Date: _____

No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?
 YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

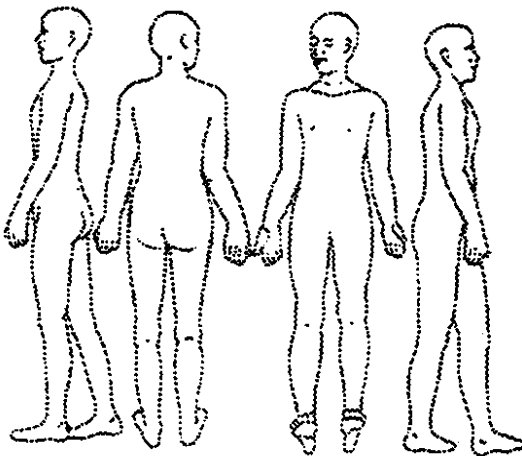
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

Absolute Chiropractic, Inc.

PATIENT CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services.
- **Payment:** Your PHI will be used, as needed, to obtain payment for your health care services.
- **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice.
- **In emergency situations or to avert serious health/safety situations.**
- **To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.**
- **To organ, tissue, and other donations organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences (or a positive indication)**

Special Cases

- **To contact you about appointment reminders, treatment alternatives, and other health related benefits and services.**
- **In fundraising for ourselves**
- **To the sponsor of your health plan**

Other

- **All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.**

Your right

Restrictions: To request restricted access to all or part of your PHI. To do this, you must request in writing and it must state the specific restriction requested and to whom you want the restriction to apply. If your physician feels it is your best interest to permit use and disclosure of your PHI, we are not required to grant your request.

Confidential Communications: To received correspondence of confidential information by alternate means or location. We will accommodate reasonable requests made in writing.

Access: To inspect or receive copies of your PHI that is contained in a designated record set for as long as we maintain the protected health information.

Amendments: To request changes made to your PHI that is contained in a designated record set for as long as we maintain the protected health information. In certain cases, we may deny your request for an amendment.

This notice: To obtain a paper copy of this notice from us, upon request. I understand that a full and more detailed notice is available to me at any time, located at the front desk.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

I acknowledge receipt of this notice:

Sign _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____