

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

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

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

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

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

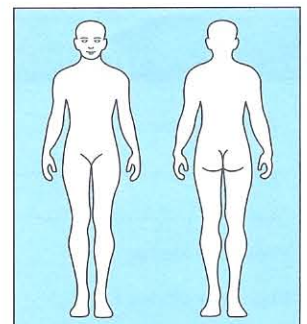
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                     |                              |                             |                     |                              |                             |                      |                              |                             |                              |                              |                             |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| AIDS/HIV            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____                  |                              |                             |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |
| Chicken Pox         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |
|                     |                              |                             |                     |                              |                             | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking Packs/Day \_\_\_\_\_  
 Alcohol Drinks/Week \_\_\_\_\_  
 Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_  
 High Stress Level Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_  
 Pharmacy Phone (\_\_\_\_\_) \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted on the following manner (check all the apply):**

<input type="checkbox"/> <b>Home Telephone</b>	<input type="checkbox"/> <b>Written Communication</b>
<input type="checkbox"/> O.K. to leave message with detailed information	<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> O.K. to mail to my work/office address
	<input type="checkbox"/> O.K. to fax to this number _____
<input type="checkbox"/> <b>Work Telephone</b>	<input type="checkbox"/> <b>Other</b>
<input type="checkbox"/> O.K. to leave message with detailed information	
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Email

\_\_\_\_\_  
Patient's or Patient's Legal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosures of, and requests for PHI to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

### Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description/Purpose of Disclosures	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T = Treatment Records; P = Payment Information; O=Healthcare Operations; A=Authorized on File; D-Discretionary

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

CANCELLATION/ NO SHOW POLICY

You are a vital component to your own chiropractic sessions being a success. It is your responsibility to follow the plan of care designed by Dr. Corps. This includes home exercises, lifestyle changes, and keeping your scheduled appointments.

Please provide at least 24 hours notice if you are unable to attend your scheduled appointment. Otherwise a fee may be charged to your account. After three consecutive no shows or cancellations without proper notice, you may be discharged from the office.

This policy stands for the benefit of all patients, so that they may receive their treatments in a timely manner. Please do not be late. After 15 minutes of the scheduled appointment time, the office reserves the right to reschedule your appointment.

By signing this form, you have read and understood to the best of your knowledge the cancelation/ no show policy for Tampa Family Chiropractic.

Patient  
(Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient  
(Signature): \_\_\_\_\_

# TAMPA FAMILY CHIROPRACTIC

8001 N. Dale Mabry Highway, BLDG 301, Tampa, FL 33614

Phone: (813) 935-8906 (Fax): 813-931-8393

## AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient Name: (Printed) \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HOSPITAL/DOCTOR'S OFFICE/CLINIC

Clinic or Doctor Name: \_\_\_\_\_

Clinic or Doctor Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

This form authorizes Tampa Family Chiropractic to obtain complete medical records, reports, x-rays, and any information in your chart/file regarding my examination, diagnosis, treatment, prognosis, etc. This authorization includes release of information that may be of sensitive nature, specifically pertaining to drug and or alcohol abuse and or psychiatric or psychological records, HIV/AIDS test results, if any, and any information including opinions/tests and results from other treating physician records that may be in my chart. I give consent to release medical information to my requesting physician.

All Records

Specific Records \_\_\_\_\_

Please forward to:

\_\_\_\_\_ Mail: **Tampa Family Chiropractic OR** \_\_\_\_\_ Fax: **(813) 931-8393**  
**8001 N Dale Mabry Hwy.**  
**BLDG 301**  
**Tampa, FL 33614**

\_\_\_\_\_  
Signature of Patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*\*If legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization. The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request. This authorization will expire automatically 365 days after the date signed.*