Confidential Patient Information

Patient Contact Information:

Last Name:_____ **First:**_____ **Initial:**____
Nick Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Birth Date:_____ **Gender:** (□Male □Female)
Occupation:_____

Home Phone:_____
Cell Phone:_____
Work Phone:_____ Ext:____
Email:_____
Marital Status: (□S □M □W □D □Partnered)
Employer:_____

Whom may we thank for referring you? (□Insurance □Phone Book □Web Search □Drive By □Other:_____)

Partner/Parent/Guardian/Emergency Contact:

Name:_____ **Relationship**_____
Cell Phone:_____
Address:_____ **Home Phone:**_____
Birthdate:_____ **Work Phone:**_____

Patient Symptoms:

Is your condition due to an accident that that resulted from an automobile or work related injury? (□No □Yes)

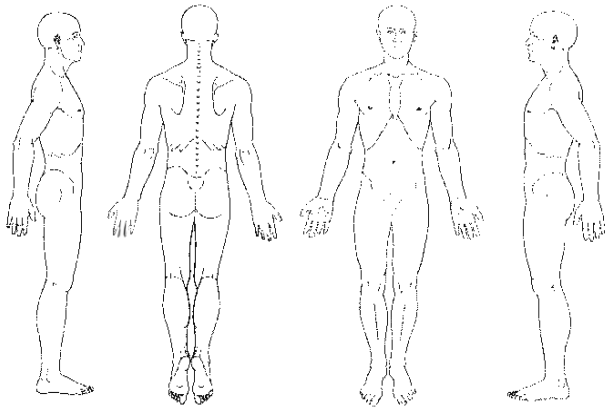
Please explain the primary reason for your appointment, specific areas of pain, discomfort and all recent injuries:_____

When did your symptoms first appear_____
What caused your condition?_____
Over the past: (Days_____ Weeks_____ Months_____ Years_____)
My condition has been getting: □Gradually Worse □Rapidly Worse □Staying About the Same □Getting Better
Activities or movements painful to perform: □Sitting □Standing □Walking □Bending □Lying Down □Other:_____
Interferes with your: □Work □Sleep □Daily Routine □Recreation

I would describe my pain as: (circle as many as apply)

CONSTANT	FREQUENT	INTERMITTENT	OCCASIONAL
VERY SEVERE	SEVERE	MODERATE	DULL
STABBING	SHARP	ACHING	MILD
BURNING	TINGLING	THROBBING	NUMBNESS
SHOOTING	STIFFNESS	SWELLING	OTHER:_____

PLEASE INDICATE AREAS OF DISCOMFORT



What is your pain on a scale from 1(least) to 10 (severe)_____
How often do you have this pain?_____
Is it constant or does it come and go? _____
I have tried the following solutions for this problem:
_____
_____

New to Chiropractic: (□No □Yes) **Previous Chiropractic Care:** (□No □Yes)
Dr:_____ When?_____
For treatment of:_____
Was there a specific treatment that was successful?_____
Present Family Doctor:_____ **Phone Number:**_____

Other Doctors consulted for these health problems:
Dr. Name:_____ When:_____
Diagnosis:_____ Treatment:_____
How long did you see the Doctor?_____ How frequently?_____
Results:_____

Exercise/or Work Level:		Exercise:	Lifestyle:	Family:
□ None	□ Sitting	□ Swimming	□ Smoking (Pack/Day:_____)	# Infant(s) under 2:_____
□ Daily	□ Standing	□ Biking	□ Coffee/Caffeine (Cups/Day:_____)	# Children: _____
□ Moderate	□ Light lifting to 20#	□ Jog/Run	□ Alcohol intake (Drinks/Week:_____)	# Care giver for:_____
□ Heavy	□ Heavy lifting +20#	□ Yoga	□ High Stress (Reason:)_____	
□ Other:_____			□ Other:_____	

Current Medication:	Adverse Side Effects or Allergies:

Injuries/Surgery:	Date/Year:	Description:
Falls/Accidents: □No □Yes		
Head Injuries: □No □Yes		
Broken Bones/Dislocations: □No □Yes		
Previous Hospitalizations: □No □Yes		
Surgeries: □Head □Neck/Throat □Back □Abdominal □Chest / Heart / Lungs □Other:_____		

Financial Responsibility and Insurance Information: ***Please give your insurance card and photo ID to the front desk to copy***

Who is responsible payment (the primary card holder)? □Self □Other:_____ DOB:_____
Relationship to patient):_____

Financial Policy:

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

IF you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Ultimately, you are responsible for any care that your insurance does not cover.

Pine Lake Chiropractic Clinic also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms"

Pine Lake Chiropractic is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the HIPPA *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.,* which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X_____ _____
Signature of Patient

_____ _____
Printed Name **Date**

Consent For Treatment Of Minors Or Dependants:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X_____ _____ _____
Signature of Parent or Guardian **Date** **Relationship to Patient**

Health History

Patient Name:_____ **Date**: _____

PLEASE CIRCLE ALL THAT APPLY

General:
Mumps / Measles / Chicken Pox
Mononucleosis
Psychiatric Care
STD / Herpes / HIV (AIDS)
Rheumatic Fever / Scarlet Fever
Typhoid Fever
Prosthesis
Osteoporosis
Chronic Fatigue / Fibromyalgia
Balance Problems
Bruise or Bleed Easily
Arthritis / Bursitis
Headaches
Migraine / Cluster / Tension/Stress
Pinched Nerve
Disc problems
Edema / Where:_____
Poor Sleep / Insomnia
Hepatitis

Head / Face:
Restricted Movement
Facial / Jaw Pain / TMJ
Eye or Sinus Pain
Facial Muscle Spasms

Neck:
Restricted Movement
Neck Muscle Spasms
Sore / Aching "Top Shoulder"

Upper Back:
Restricted Movement
Painful / Stiff joints
Pain Below Shoulder Blades
Pain Around Collar Bone

Chest / Mid Back:
Restricted Movement
Arms / Shoulders / Hands
Rib Cage Pain
Hiatus Hernia

Lower Back:
Restricted Movement
Lumbago
Painful Tail Bone
Buttock Pain / Hip Pain
Sciatica

Leg Pain
Restricted Movement
Pain Thigh / Calf / Foot / Toes
Leg Cramps
Sore / Weak Muscles

Skin:
Skin Disorders
Change in Hair or Skin
Acne / Pimples / Boils
Hives or Allergies
Itching / Dryness
Shingles

Eye, Ear, Nose & Throat:
Vision Problems
Glaucoma
Eye Inflammation / Eye Strain
Light Sensitivity
Zigzag Flashes
Visual Disturbances
Hearing Loss / Tinnitus
Ear Discharge / Chronic Earaches
Chronic Ear Problems
Sinus Drainage
Sinusitis / Chronic Infection
Nose Bleeds / Chronic
Sore Mouth / Gums
Difficulty Chewing or Swallowing
Dental Issues / TMJ / Sore Jaw Area
Hoarseness
Thyroid Problems
Tonsillitis / Removed:_____

Respiratory:
Difficulty Breathing
Allergies
Asthma / Wheezing
Chronic Cough / Chronic Chest Colds
Bronchitis / Chronic Bronchitis
Coughing / Phlegm / Blood
Pneumonia / Chronic Pneumonia
Tuberculosis / Whooping Cough
Emphysema

Nervous system:
Paralysis
Convulsions
Confusion
Parkinson's Disease
Multiple Sclerosis
Depression
Irritability
Nervousness / Anxiety
Fainting / Dizziness
Personality Changes
Suicide Attempt(s)
Insomnia
Forgetfulness
Tension
Tremors / Tingling
Hot / Cold spots

Cancer:
Please Explain:_____
_____
_____
_____
Treatment:_____
_____
_____
_____

Cardio-Vascular:
High/Low Blood Pressure
Anemia
Stroke
Heart Attack
Rapid /Slow / Irregular Heart Beat
Pacemaker
Pain Over Heart
Hardening of Arteries
Bleeding Disorders
Poor Circulation
High Cholesterol
Blood Clots

Gastro-Intestinal:
Pain
Stomach Disorder
Food Allergies
Diabetes
Excessive Thirst / Hunger
Ulcers / Gastritis / Heartburn
Poor Appetite
Distention of Abdomen
Belching
Nausea / Vomiting / Vomiting Blood
Chronic Nausea
Liver Trouble
Jaundice
Bulimia / Anorexia
Obesity
Diverticulosis / Colitis
Diarrhea / Constipation
Stool Black / Bloody

Genital/Urinary:
Pain
Bladder Trouble
Bed Wetting
Infections/Chronic Infection
Hemorrhoids
Kidney Disease/Infections
Kidney Stones
Urine Disorder
Excessive/Scanty/Painful
Discolored/Blood/Pus
Yeast Infection
Prostate Problems
Impotency
Prostatitis

Female Specific:
Are you Pregnant? □No □Maybe □Yes
Due Date:_____
Complications:_____
Number of Pregnancies:_____
Taking Birth Control Pills: □No □Yes
Breast Health Issues:
Lumps / Congestion
Tumors / Implants
Menopause: □No □Yes
Hormone Replacement Therapy (HRT)
Hot Flashes
Other:_____
_____
_____

HIPPA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly know as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

A partial list of how we may use and disclose health Information about you:

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.
- The practice maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter this office.

As our patient, your rights regarding Health Information about you:

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

□ Any member of my immediate family □ Spouse ONLY

□ Other(s) as specified:_____

X_____ _____

Signature **Relationship to Patient**

_____ _____

Printed Name **Date**