Welcome to Our Office

Name: ________________________________ ______ ____
First M Last

Address: ____

City: ____ State: __________ Zip:__________________

Telephone: (Home) __________________ (Cell) ______________________ (Work) _________________________

Social Security Number: _________________________________ Date of Birth: _____/______/______

E-mail Address or cell phone carrier (for appointment reminders) ____

Sex: M F If Female, is there any chance you may be pregnant? □ Yes □ No

Marital Status: □ Single □ Married □ Divorced □ Widowed

Preferred method of communication for patient reminders (Circle one): Email /Text

Preferred Language: __________________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

WHAT BROUGHT YOU IN TODAY?

- □ Headache
- □ Neck Pain
- □ Hip Pain
- □ Maintenance/Wellness Care
- □ Mid Back Pain
- □ Low Back Pain
- □ Upper Back Pain
- □ Other: _________________________________
- □ Radiating Pain Down the Leg
- □ Radiating Pain in Shoulder/Arm
- □ Shoulder Pain

What activities do these problems effect or limit? ____

____

HEALTH HISTORY

Neurological Issues: □ none □ anxiety/panic □ depression □ memory □ dizziness □ headache
□ numbness/tingling □ other:____

Head, Ear, Nose, & Throat: □none □ vision issues □ hearing issues □ difficulty swallowing □ hoarseness
□ other: ____

Heart Issues: □ none □ high blood pressure □ chest pain □ pacemaker □ irregular heart beat □ swelling lower legs
□ heart attack □ stroke □ other: ____

Breathing Issues: □ none □ shortness of breath □ asthma □ emphysema □ allergies □ chronic cough
□ other: ____

Digestion Issues: □ none □ indigestion/heartburn □ gallbladder issues □ diarrhea □ constipation □ abdominal pain
□ other: ____

Urinary Issues: □ none □ frequent □ pain/burning □ infections/UTI □ incontinence
□ other: ____

Endocrine: □ none □ Diabetes □ Thyroid Issues □ Pancreas Issues
□ other: ____

Skin Issues: □ none □ eczema/psoriasis □ bruises easily □ skin cancer (type) ____________________________
□ other: ____

□ **Cancer:** □ none (include type and year) ____

□ **Surgeries:** □ none (include year) ____

□ **Past Illnesses:** □ none (include details) ____

□ **Accidents/Injuries** □ none (include details) ____

FAMILY HEALTH PROFILE

Please list below any illness your direct family members have or have had in the past.

Mother: ____

Father: ____

Grandmother: ____

Grandfather:____

Siblings: ____

EMPLOYMENT

Occupation: _____________________________□ Full Time □ Part Time Employer: _____________________________________

LIFESTYLE CHOICES

Alcohol intake □ None □ 1-3 □ 4-6 □ 7+ drinks per week

Smoking Status (Circle one): Social Smoker / Light Smoker /Moderate Smoker/ Heavy Smoker/ Former Smoker / Never Smoked

Stress level □ None □ Mild □ Moderate □ Off the charts

Exercise frequency □ never □ 1-2 □ 3-4 □ 5+ days per week □ Meditate/yoga

Nutrition □ Vit. D □ Fish oil □ Multivitamin □ Mostly Processed Diet □ Whole Food Diet
□ Other supplements____

Previous chiropractic care? □ No □ Yes:
Who:____________________________________ How long? ________________________ Last visit? _________________
How was your experience? ____

Referred by: ____

□ **I choose to decline receipt of my clinical summary after every visit**

Beach Chiropractic Center

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Beach Chiropractic Center and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren.

OBLIGATION OF PAYMENT

I direct and assign payment from my insurance company to Beach Chiropractic Center. I understand that my insurance policy is a contract between my insurance company and me. I am responsible to Beach Chiropractic Center for any charges not covered by my insurance, including co-payments, deductibles and fees for non-covered services.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

To reduce wait time, co-payments will be collected upon signing in. To keep costs down, my payment, as well as charges for non-covered services, are due at the time of service. My patient account balance may not exceed $100. Any balance remaining on the account after insurance pays, will be due upon receipt of my statement. If payment is not made, I understand that Beach Chiropractic Center may take action to collect its fees. I agree to pay all costs incurred by Beach Chiropractic Center for collecting its fees, including an attorney's fee of thirty-five percent (35%) of the unpaid bill and a return check fee of $25.00.

BILLING QUESTIONS AND CONCERNS

Please direct all billing inquires to our billing office at 430-0990

APPOINTMENT POLICY

If a scheduled appointment is not canceled one hour prior to the designated time, you may be charged a missed appointment fee of $20.00.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____________________ have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

Print Name: ______________________________ Date: ______________________________

Signature: ____

Personal Representative Information (If Applicable)

Print Name: ______________________________ Relationship to Patient: ______________________________

Signature: ____

Date: ____

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) ____

____

Staff signature Date