

South Charlotte Spine & Wellness

Office Use Only

Chart# _____

Date: _____

PLEASE FILL OUT ALL INFORMATION

PERSONAL INFORMATION

Last Name: _____ First Name: _____ M: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: ____/____/____ Sex: **M** **F** Social Security #: _____ - _____ - _____

Single _____ Married _____ Widowed _____ Divorced _____ Spouse's Name: _____

E-mail: _____ Referred to this office by: _____

Emergency Contact Name: _____

Your Occupation: _____ Employer: _____

Employer Address: _____

Purpose of this visit: _____

Have you ever been to another doctor for this problem? **Y** **N** Who: _____

Is this condition: Job Related _____ Auto Related _____ Other _____ (explain) _____

INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____

Policyholder: _____ Relationship: _____

Policyholder Birthdate: ____/____/____ Policyholder Employer: _____

Policyholder SS#: ____/____/____ Policy #: _____ Group/Plan #: _____

I, the undersigned, certify that I have insurance coverage with _____ and assign directly to South Charlotte Spine and Wellness 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: _____ Date: _____

PATIENT HISTORY

FIRST COMPLAINT: _____ History of complaint: _____

- Date when symptoms first appeared: ____days, weeks, months, years Did it begin: Gradual Sudden Slowly over time
- Type of Pain: Dull Sharp Aching Burning Numb Stabbing Shooting Throbbing Stiff Tight Tingling
- How often you notice these symptoms: 100% 75% 50% 25% 10% Is the pain worse in: AM PM No Difference
- Does the pain radiate into your: Right arm Left arm Right leg Left leg Does not radiate
- What makes the symptoms worse: Standing Sitting Lifting Bending
Other _____
- What makes the symptoms better: Heat Ice Medication Massage Other _____
- Pain scale: 0 (no pain) 1-2 (slight) 3-4 (mild) 5-6 (moderate) 7-8 (severe) 9-10 (extreme)
- Other Dr. Treated this Complaint: Y N (Who, Where, When)

OTHER COMPLAINT: _____ History of complaint: _____

- Date when symptoms first appeared: ____days, weeks, months, years Did it begin: Gradual Sudden Slowly over time
- Type of Pain: Dull Sharp Aching Burning Numb Stabbing Shooting Throbbing Stiff Tight Tingling
- How often you notice these symptoms: 100% 75% 50% 25% 10% Is the pain worse in: AM PM No Difference
- Does the pain radiate into your: Right arm Left arm Right leg Left leg Does not radiate
- What makes the symptoms worse: Standing Sitting Lifting Bending
Other _____
- What makes the symptoms better: Heat Ice Medication Massage Other _____
- Pain scale: 0 (no pain) 1-2 (slight) 3-4 (mild) 5-6 (moderate) 7-8 (severe) 9-10 (extreme)
- Other Dr. Treated this Complaint: Y N (Who, Where, When)

PLEASE LIST ALL PAST SURGERIES:

Type: _____ When: _____ Doctor: _____
Type: _____ When: _____ Doctor: _____
Type: _____ When: _____ Doctor: _____
Type: _____ When: _____ Doctor: _____

PLEASE LIST ANY MEDICATIONS OR VITAMINS YOU ARE CURRENTLY TAKING:

Type: _____ Condition: _____ Type: _____ Condition: _____
Type: _____ Condition: _____ Type: _____ Condition: _____

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY (cont)

PLEASE CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING SIGNS / SYMPTOMS / DISEASES:

Headaches	Dizziness	Nausea	Light Bothers You
Pain In Or Behind Eyes	Blurred Vision	Memory Loss	Ringing in the ears
Ear Aches / Ear Infections	Sinuses	Allergies	Hay Fever
Nose bleeds	Sore Throat	Upset Stomach	Vomiting
Diarrhea	Constipation	Blood In Stool	Loss Of Energy
Nervousness	Low Resistance	Frequent Urination	Painful Urination
Blood In Urine	Fatigue	Inability To Control Urine	Prostate Trouble
High Blood Pressure	Chest Pain	Difficulty Breathing	Shortness Of Breath
Asthma / Emphysema	Chronic Cough	Tension	Kidney Stone / Infection
Neck Pain	Stiff Neck	Pain Between Shoulder Blades	Low Back Pain
Cold Hands / Feet	Sleeping Problems	Pain/Numbness In Hands, Feet	Depression
WOMEN ONLY:			
Are You Pregnant? Y or N	Irregular Cycles	Excessive Flow	Cramps/Backache
Painful Periods	C-Section	Date Of Last Pap Test_____	Hysterectomy

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING DISEASES:

Appendicitis	Pneumonia	Rheumatic Fever	Polio
Tuberculosis	Anemia	Cancer	Measles
Mumps	Chicken Pox	Eczema	Stroke
Heart Disease	Arthritis	Epilepsy	Diabetes
Thyroid Conditions	Whooping Cough	Asthma	Other_____

FAMILY HISTORY:

	<u>Diabetes</u>	<u>Heart</u>	<u>Kidney</u>	<u>Cancer</u>	<u>Back</u>
Parents: Mom (M) Dad (D)	M D	M D	M D	M D	M D
Siblings: Sister (S) Brother (B)	S B	S B	S B	S B	S B

PATIENT SIGNATURE _____ **DATE** _____

South Charlotte Spine and Wellness HIPAA Notice of Privacy Practices

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at South Charlotte Spine and Wellness we may use or disclose personal and health information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessments or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If you are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intended for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you received chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files, in addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and health information therein. We are also required to provide you with this notice of our privacy practices with the respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

You may complain to South Charlotte Spine and Wellness or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Effective Date of Policy: April 14, 2003

Please sign below to acknowledge that you have received the notice of our privacy practices:

Print Name: _____

Sign Name: _____