# Spencer Family Chiropractic

503 W. 10th St ~ Rome, GA 30165 ~(706) 234-3031

## PERSONAL HEALTH HISTORY

*Welcome to our Family!*

Date: _____ Patient ID# _____

Name: _____ Nick Names: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____
Date of Birth: _____ Age:_____ Social Security #: _____

Marital Status: S M D W Spouse's Name: _____ Age: _____
Children's Name(s)/Age(s): _____

Name of Employer: _____ Occupation: _____
Employer Address: _____ Employer Phone#: _____
**Referred By:** _____

Name of previous Chiropractors: _____
When was your last visit? _____ How Long were you receiving Chiropractic Adjustments? _____

**Reason for coming in:** _____

**INJURIES:**
What accidents have you had (ex. bicycle, car, motorcycle, sports, slips/falls) at work or at home?
Include dates: _____
_____
Were you ever knocked unconscious? YES [ ] NO [ ]

What fractures or broken bones have you had? Include dates: _____
_____

**SURGERY:**
What major or minor surgery have you had? Include dates: _____
_____

**MEDICATIONS:**

| Present prescription drugs | Past prescription drugs | Over-the-counter drugs (aspirin, laxatives, cough syrup, etc) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**THERAPY:**
Are you presently under any therapeutic care? _____ What type? _____
What therapeutic care have you been under in the past (chemo, physio, electro, etc.) Include dates: _____
_____

**BIRTH RECORD:**
Type of birth (vaginal, cesarean, forceps, vacuum, etc.) _____Complications during your mothers pregnancy or during your birth? _____

**CURRENT HEALTH:**
How would you describe your current health? _____
How would you describe your family's health? _____
Describe your: Vision _____ Hearing _____ Coordination _____
Do you use an of the following: TOBACCO ALCOHOL COFFEE/TEA COLA MILK
Level of stress in your life: MILD MODERATE EXTREME Rate your stress:1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following: ___ Bottled water ___ Vitamins ___ Health food products (organic products, etc.)

**FINANCIAL INFORMATION:**
Who is responsible for this account? SELF SPOUSE OTHER Name if other: _____
What method of payment will you be using? INSURANCE CASH CHECK CREDIT CARD OTHER
Name of insurance company: _____ Name of insured: _____
Date of birth of insured: _____ Policy number: _____
Insured SS#: _____ Group number: _____
Insured Employer: _____ Employer Phone #: _____

**Please check any of the following that give you difficulty or you have had recently**

__ Headaches
__ Shooting head pains
__ Sinus trouble
__ Loss of smell
__ Menstrual cramps/pain
__ Menstrual irregularity
__ Asthma
__ Inflammation of throat
__ Thyroid trouble
__ Facial twitch
__ Loss of Memory
__ Fatigue
__ Depression
__ Spinal curvature
__ Chest pain
__ Ear ache
__ Fainting
__ Loss of balance
__ Ringing in ears
__ Blurred vision
__ Lights bother eyes
__ Neck pain
__ Muscle spasms in neck
__ Shoulder/arm tightness
__ Shoulder/arm pain
__ Pins & needles in arms
__ Pins & needles in hands
__ Pins & needles in legs
__ Numbness in arms/hands
__ Prostate trouble
__ Bed wetting
__ Cancer
__ Shortness of breath
__ Mid-back pain
__ Heart attack
__ Low blood pressure
__ High blood pressure
__ Anemia
__ Nerves/nervousness
__ Inner tension
__ Irritability
__ Gallbladder trouble
__ Indigestion
__ Intestinal gas
__ Low back pain
__ Stroke
__ Arthritis
__ Seizures
__ Numb legs/feet
__ Constipation
__ Kidney trouble
__ Allergies
__ Hayfever
__ Diabetes
__ Painful joints
__ Swollen joints
__ Cold hands
__ Swollen ankles
__ Cold feet
__ Pain in legs/feet
__ Hip pain
__ Jaw pain/TMJ
__ Ulcers

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understanding it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

# Authorization and Release

Patient's Name Account Number

West 10th St Chiropractic
dba. Spencer Family Chiropractic
503 W. 10th St.
Rome, GA 30165

Dr. Mary Spencer
Dr. Timothy Ryan

## Authorization to Release Information

I authorize the doctor and his/her staff named above to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Signature Witness Date

## Authorization to Pay Doctor/Clinic

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named above as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

Signature Witness Date

Authorization to Pay
Release Authorization
is granted to
Physician Tax ID

*West 10th Street Chiropractic DBA Spencer Family Chiropractic

# Health Care Authorization Form

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES (West 10th Street Chiropractic) TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

**Specific Authorizations**

- ☐ I give permission to (West 10th Street Chiropractic) to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information.

- ☐ If (West 10th Street Chiropractic) contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

(OPEN ROOM AUTHORIZATION – OPTIONAL)

- ☐ I give (West 10th Street Chiropractic) permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office my overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

- ☐ By signing this form you are giving (West 10th Street Chiropractic) permission to use and disclose your protected health information in accordance with the directives listed above.

## Expiration

The Authorization shall expire on the following date: 20 YEARS FROM DATE OF SIGNATURE

## RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of (West 10th Street Chiropractic). The written notice must contain the following information:

Your Name, Social Security Number, and your Date of Birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by (West 10th Street Chiropractic) for its own use/disclosure of PHI. (minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, (West 10th Street Chiropractic) will not refuse to provide treatment.

You have the right to inspect or coy the PHI to be used/disclosed.

* * A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Personal Represtative: _____

Description of Representative's Authority to Act for Patient: _____

_____

*West 10th Street Chiropractic DBA Spencer Family Chiropractic

# Notice of Receipt of Privacy Notice of West 10th Street Chiropractic

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of West 10th Street Chiropractic, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (E.g., Attorney-in-Fact, Guardian, Parent if a minor). Relationship

Date Signed ___/___/___ _____

Witness