North Office: 1802 Chapel Hills Dr. Suite E P: 719-531-7188 F: 719-531-0880
South Office: 2620 Tenderfoot Hill St. #10 P: 719-527-6747 F: 719-579-9623

New Patient Paperwork

PATIENT INFORMATION

Today's Date: _____

Name: _____ DOB: _____ Age: _____ Sex: M____ F____

Address: _____ City: _____ State_____ Zip: _____

Email: _____ Best Phone #: _____

Social Security#_____ Married: ____ Widowed: ____ Single: ____ Separated: ____ Divorced: ____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Work #: _____

Spouse Name: _____ Spouse DOB: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group#_____

Subscriber's Name: _____ Relationship to patient: _____

Subscribers DOB: _____ Who is responsible for this account? _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have coverage with the above-named insurance company and assign directly to Springs Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance submissions. Springs Chiropractic, P.C. may use my health care information and may disclose such information to my 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.

Patient Printed Name: _____ Patient Signature: _____

Guardian Signature: _____ Today's Date: _____

ACCIDENT INFORMATION

Is condition due to an accident? ___Yes ___No Type of accident: ___Auto ___Work ___Home ___Other

To whom have you made a report of accident? Auto Ins___ Employer___ Worker Comp.___ Other___

Attorney Name (if applicable) _____

MEDICATIONS: (Please list as medications &/or Supplements)

_____

_____

ALLERGIES:

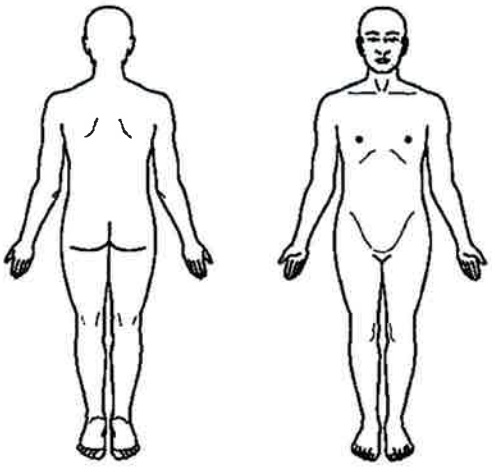
_____

_____

PATIENT CONDITIONS:

Reason for visit _____

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



When did your symptoms appear? _____

Is this condition getting progressively worse? Yes ____ No _____

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 ____ Other: _____

Activities that are painful: 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 doctors 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 _____

Please mark if you have had any of the following:

___AIDS/HIV
___Alcoholism
___Allergy Shots
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding disorders
___Breast Lump
___Bronchitis
___Bulemia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___Fractures
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disk
___Herpes
___High Cholesterol
___Kidney disease
___Liver Disease
___Measles
___Migraine
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Osteoporosis
___Pacemaker
___Parkinson's
___Pinched Nerve
___Pneumonia
___Polio
___Prostrate Problem
___Prosthesis
___Psychiatric Care
___Rheumatoid Arthritis
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Suicide Attempt
___Thyroid problems
___Tonsilitis
___Tuberculosis
___Tumors, growths
___Typhoid Fever
___Ulcers
___Vaginal Infection
___Venereal Disease
___Whooping Cough

Other: _____

_____

EXERCISE - WORK ACTIVITY - HABITS

___None	___Sitting	___Smoking	Packs/Day _____
___Moderate	___Standing	___Alcohol	Drinks/Week _____
___Daily	___Light Labor	___Coffee/caffeine drinks	Cups/Day _____
___Heavy	___Heavy Labor	___High Stress Level	Reason _____

Are you pregnant? ___Yes ___No Due Date: _____

Injuries/Surgeries you have had **Description**

Falls _____
Date(s): _____

Head Injuries _____
Date(s): _____

Broken Bones _____
Date(s): _____

Dislocations _____
Date(s): _____

Surgeries _____
Date(s): _____

Patient Printed Name: _____ Patient Signature: _____

Guardian Signature: _____ Today's Date: _____

Springs Chiropractic

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INFORMED CONSENT FOR TREATMENT

Patient: _____ DOB: _____

Phone: _____ Email: _____

Medical doctors, chiropractic doctors, and osteopathic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjusting is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware, that like exercise, it is common to experience muscle soreness after the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc disease, or other abnormality is detected, extra caution will be exercised during treatment.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I am aware that there is no certainty that I will achieve these benefits

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Signature: _____ Date: _____

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THIS NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW NOTICE CAREFULLY.

Once you sign Springs Chiropractic's registration & consent form, we may use and disclose your medical information to treat you, to obtain payment, and to operate the practice.

Examples of uses and disclosures for treatment;

If a physician from our practice refers you for outside testing and needs to call that facility for test results, the staff may give your name and reason for testing to that facility.
A physician that you were referred to or from may call to discuss your Personal Health Information (PHI) with our physician.

Example of use and disclosure to obtain payment:

The practice's billing office may submit a claim form that contains your name, address, social security number, diagnoses and procedures performed in our office to your insurance company and discuss this information if necessary with their staff to procure payment of claim.

Examples of use and disclosure to operate the practice:

The practice physicians and staff may audit your medical records.
The practice staff may mail you information and billing statements.
The practice staff may leave messages asking for a return call to discuss medical or financial issues.
This practice may use or disclose your PHI with your written authorization. You may revoke authorization in writing.

This practice may use or disclose PHI for other purposes, and without your consent, if the law requires us to disclose this information to government authorities. Examples of such uses; suspected abuse and infectious diseases.

You have the following rights regarding your Protected Health Information, and the practice must act on your request within 60 days.

You may request a paper copy of this notice.
You may request that your information be amended (must be done in writing).
You may inspect and copy your own Protected Health Information.
You may request restrictions on use of certain PHI, but we are not required by law to agree to a restriction. You may request information to be given to other individuals (must be in and signed and dated).
We are required by law to maintain the privacy of PHI. You may complain to the practice manager if you believe your rights have been violated. This must be in writing, or you may complain to the U.S. Department of Health and Human Services.

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "Need to Know" basis, and then kept confidential. We will comply with Federal, State, and local laws on "Confidentiality of Medical Information".

I, _____, consent to allow Springs Chiropractic to use and disclose PHI about me for the purpose of treatment, payment, and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as also described above.

_____ _____

Patient Signature (Parent/Guardian if minor) Today's Date

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PATIENT'S NAME: _____ DOB: _____

CELL#: _____ WORK #: _____ HOME #: _____

1. What is your current smoking status?

Everyday Smoker: _____ Occasional Smoker: _____ Never Smoked: _____ Former Smoker: _____

CURRENT SMOKER: Number of years/months you have SMOKED _____
FORMER SMOKER: Number of years you smoked_____Number of years since you QUIT _____

2. Race?

Caucasian: _____ Black/African American: _____ Asian: _____ American Indian/Alaska Native: _____ Decline: _____

3. Ethnicity?

Hispanic/Latino: _____ Non-Hispanic/Latino: _____ Decline: _____

4. Preferred Language?

English: ___ Spanish: ___ French: ___ Italian: ___ Japanese: ___ Portugese: ___ Russian: ___ Other: ___ Decline: ___

5. Do you have any allergies? (Please list)

_____

_____

6. Are you currently taking any medicatons/supplements? (Please List)

_____

_____

7: Height: _____ Weight: _____

OFFICE USE

BP: _____ HR: _____