

Auburn Hills
CHIROPRACTIC

Dr. Jacob Holdren
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PH: (316) 721-2220 / FAX: (316) 721-2226

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Patients First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Home Phone: _(____) _____

Marital Status: M S W D Sex: M F Name of Spouse: _____ Do you have children: Yes No

Address: _____ City/State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Office Phone: _(____) _____

Emergency Contact Name: _____ Contact Phone: _(____) _____

How did you hear about our clinic: _____ E-mail: _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Are you in pain: Yes No

Rate your pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

On the diagram to the right, please circle the areas where you are feeling pain -----

Did your injury occur during: Work Auto Accident
 Sports/Play Routine/Household Activity

When did your condition/accident occur: ____/____/____

Where did your injury occur: _____

Please explain what happened: _____

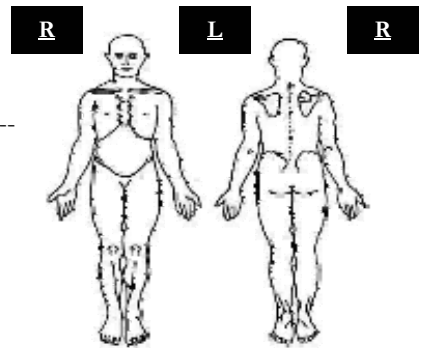
Is your condition getting worse: Yes No Constant Comes and Goes

Is your condition interfering with your: Work Sleep Daily Routine If so, how: _____

Has this or something similar happened in the past: Yes No Explain: _____

Have you ever been treated by a medical physician for this pain: Yes No
Office or Dr.'s Name: _____ Office Phone: _(____) _____

Have you ever been treated by a chiropractor: Yes No
Office or Dr.'s Name: _____ Office Phone: _(____) _____



Please list any medication you are currently taking: _____

Please list anything that you may be allergic to: _____

Please list any surgeries that you have had and when: _____

Do you or anyone in your family have or have had any of the following diseases, medical conditions or procedures?

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shingles | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Fainting/Seizers/Epilepsy | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Sinus Problems/Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sever Back Problems | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Artificial Bones/Joint Implants | |

Have you ever been in an motor vehicle accident: Yes No If yes, when and were your injured: _____

Do you take Supplements or Vitamins: Yes No Do your exercise: Yes No _____ hour per day/week

Do you smoke: Yes No How much: _____ How long: _____

Are your dieting: Yes No If yes, what date did you begin: ____/____/____

For Women: Are you taking Birth Control: Yes No

Are your pregnant: Yes No If so, for how many weeks: _____ Are your nursing: Yes No

Do you have health insurance: Yes No

Insurance Company: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Date of Birth: ____/____/____ Social Security Number: _____ - _____ - _____

2nd Insurance Company: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Date of Birth: ____/____/____ Social Security Number: _____ - _____ - _____

- ❖ We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between the doctor and the patient.
- ❖ I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care, as determined by the doctor, any fees for professional services will be immediately due and payable.
- ❖ I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office.
- ❖ 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 authorize direct payment of medical benefits to Auburn Hills Chiropractic from my insurance company.
- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If the account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Patient's/Guardian's Signature

Date

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this clinic and your rights concerning those records. Before we begin any health care services we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow Auburn Hills Chiropractic to use their PHI for the purpose of treatment, payment, healthcare services, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. This clinic will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions but will consider and discuss those with the patient.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known to this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our office manager about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care services, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

PATIENT HEALTH INFORMATION CONSENT

Patients/Guardians Signature

Date