# POMAJZL Chiropractic

## Patient Information

Name:_____ Birthdate:_____

Address:_____ City:_____ State:_____ Zip_____

Social Security Number:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer:_____ Employer Address:_____

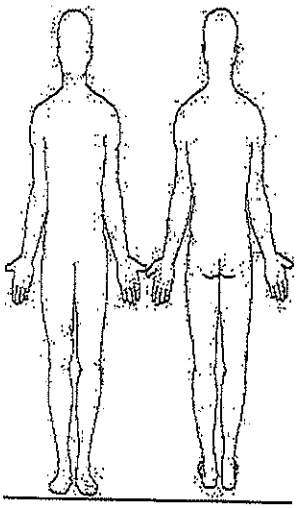
Email Address:_____

Was this a work/auto accident injury?_____ If yes describe injury:_____

## Emergency Contact Information

Name:_____ Phone:_____

Shade areas where pain is



### Chief Complaint/History

What part bothers you the most?_____
What caused this pain?_____
When did this pain start (date)?_____
Is the pain due to an auto or personal accident? **Yes** **No**
Is the pain due to a work injury? **Yes** **No**
Primary Physician:_____
Has your primary physician ever treated you for this pain? **Yes** **No**
Have you ever been treated for back or neck pain? **Yes** **No**
Have you ever been seen for chiropractic care? **Yes** **No**
Have you ever had surgery on your back or hips? **Yes** **No**
History of cancer or tumor? **Yes** **No**
Female Patients Only: Are you pregnant now? **Yes** **No**
Date of last period?_____

| **History:** **Have You...** | **Yes** | **No** |
|---|---|---|
| Been diagnosed with high blood pressure? | ☐ | ☐ |
| Been diagnosed with or currently have diabetes? | ☐ | ☐ |
| Ever been knocked unconscious? | ☐ | ☐ |
| Have you been hospitalized in the last 5 years? | ☐ | ☐ |

If yes please list date and reason for hospitalization:_____

(See Back side)

**Family History:** (circle all that apply and list relationship-IE: sister, brother, mother, father, son, or daughter)

Cancer_____ Diabetes_____ Eczema_____ Epilepsy_____

Multiple Sclerosis_____ Stroke_____ Parkinson's Disease_____

Amyotrophic Lateral Sclerosis (ALS) _____ Heart Disease_____

**Personal Information**

**Height:**_____ft_____in **Weight:**_____ **BP:**_____/_____ mmHG

**Current Medications &Dosage:**_____

_____

**Medication Allergies & Reactions**_____

**Smoking Status:**

Current Everyday Current Some Day Former Never (Fewer than 100 cigarettes)

**Alcohol use:**

None Casual Moderate Heavy

**Drug use:**

None Recreational Addiction

**Caffeine Use:**

None Less than 3 drinks per day 3-6 drinks per day More than 6 drinks per day

**Exercise:**

Never Daily Weekly Other_____

**Race (Please Circle Only One):**

American Indian or Alaska Native African American/Black Asian

Native Hawaiian or Other Pacific Islander White

**Ethnicity:** *Hispanic or Latino* *Not Hispanic or LatinoNot Provided*

**Preferred Languange:**_____

**Patient Referral**

**Who can we thank for referring you?**_____

**Patient Consent:** 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 of all services rendered at the time of visit unless other arrangements have been made with the doctor.**

**I authorize the doctor 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 have read and agree to the above statements.

**Patient Signature:**_____ **Date:**_____

**Signature of Parent or Guardian in a minor:**_____

# PLEASE READ AND SIGN THE AGREEMENTS BELOW

**AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:**
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF POMAJZL CHIROPRACTIC ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HEREBY AUTHORIZE POMAJZL CHIROPRACTIC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO POMAJZL CHIROPRACTIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE PROVIDER AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

**PATIENT INFORMATION CONSENT:**
I UNDERSTAND THAT POMAJZL CHIROPRACTIC MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES POMAJZL CHIROPRACTIC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).
I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW POMAJZL CHIROPRACTIC'S PRIVACY NOTICE, TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE.
I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, POMAJZL CHIROPRACTIC MAY REFUSE TO UNDERTAKE MY CARE. I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING

**MEDICARE PATIENTS:**
I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO POMAJZL CHIROPRACTIC.

**HIPPA ACKNOWLEDGEMENT:**
I HAVE RECEIVED AND HAVE READ THE MOST RECENT POMAJZL CHIROPRACTIC NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

_____
(Please list authorized Representative (s) or mark N/A)

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.**

_____ _____

*Patient/Guardian Signature* *Date*