D'Olive Bay Family Chiropractic, P.C.

28080 US Highway 98 Ste. D Daphne, AL 26526
(251) 621-0341

Name: (Last) _____ (First) _____ (MI) _____

Address: (Street) _____ (City)_____ (State)_____ (Zip)_____

Home Phone #_____ **Work** #_____ **Cell** # _____

Birth Date_____ **Email** _____

Height _____ **Weight**_____ **Do you use tobacco?** _____

Marital Status: Single Married Other SS#_____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you to us / how did you hear about us? _____

Health INS: BCBS MEDICARE AETNA CIGNA NONE OTHER _____

Policy Holder: _____ **Policy Holders DOB**: _____

Is this a **Workers Comp claim**?_____ Auto **Policy Claim**?_____ Personal **Injury Lawsuit**?_____

List medical doctors seen within the past year:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

Date of last physical examination: _____

List all surgeries:

Type_____ When_____

Type_____ When_____

Type_____ When_____

Past accidents or injuries:

Type_____ When_____ Hospitalized? Yes_____ No _____

Type_____ When_____ Hospitalized? Yes_____ No _____

Type_____ When_____ Hospitalized? Yes_____ No _____

List medications and/or vitamins & minerals you are taking:

Type_____ For _____ How Long? _____

Type_____ For _____ How Long? _____

Type_____ For _____ How Long? _____

Present Complaint

What is the reason you are visiting our office today? _____

When did this begin? _____ Have you ever had this problem before? **Y** **N** When? _____

Did you problem begin: [ ] Gradually [ ] Immediately after an event

If after an event, explain the event: _____

Describe your pain: (you may check more than one)
[ ] Sharp / Stabbing [ ] Dull / Achy [ ] Numbness [ ] Weakness [ ] Shooting [ ] Throbbing

How often are the complaints present? [ ] Constant, _____Hours per day, _____Days per week, _____Days per month

What activity makes your symptom(s) **WORSE?** _____

What activity makes your symptom(s) **BETTER?** _____

What ***daily activity*** do you have trouble with as a result of your problem? _____

_____

Rate the severity of your pain at its least and greatest times by checking two boxes on scale.

0 1 2 3 4 5 6 7 8 9 10

Have you seen another health care professional for this condition? _____ Who? _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ If yes, please explain to doctor upon examination.

WOMEN: Is there any reason to believe you may be pregnant? _____

Past and Present Conditions

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Headaches_____	Dizziness_____	Weak Immune System_____
Neck Pain_____	Pins/Needles in Arms/Hands_____	TMJ_____
Low Back Pain_____	Pain in Leg / Feet_____	Pain in Joints_____
Diabetic Problems_____	Heart Problems_____	High Blood Pressure_____
Breathing Problems_____	Asthma_____	Thyroid Problems_____

Sinus Problems_____ Allergies_____ Bowel Problems_____

Eye Problems_____ Ear Problems_____ Menstrual Problems_____

Indigestion_____ Stomach Problems_____ Sleeping Problems_____

Skin Problems_____ Gall Bladder Problems_____

Constipation_____ Bladder Problems_____

Liver Problems_____ Kidney Problems_____

Weight Problems_____ Fatigue_____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve the joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at D'Olive Bay Family Chiropractic and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

*_____ INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment, and any services rejected by my insurance company.

Financial Policies:

We will try our best to inform you of your insurance benefits, however we cannot be held responsible for what your insurance company tells us over the phone. Your EOB (Explanation of Benefits) is what we have to legally go by.

*_____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original.

*_____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

*_____ INITIALS

SIGNATURE _____ DATE _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that D'Olive Bay Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review D'Olive Bay Family Chiropractic's Notice of Privacy prior to signing this document. D'Olive Bay Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of D'Olive Bay Family Chiropractic. The Notice of Privacy Practices for D'Olive Bay Family Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and D'Olive Bay Family Chiropractic's duties with respect to my protected health information.

D'Olive Bay Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the offices and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority