PATIENT DATA SHEET

General Information

First Name _____
Middle Initial _____
Last Name _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Pager No. _____
Email Address _____
Sex Male Female
Race American Indian, Alaska Native, Asian, Black or African America, Native Hawaiian, Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino
Language _____
Marital Status Single Married Other _____
Birthdate _____
Social Security _____
Referred By _____
Work Status Employed Full-time student Part-time student
Appt Reminder _____

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____

For Office Use Only

Account Number _____
Account Category _____
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set _____
Yearly Deductible _____
Deductible Rest Date _____
Unused Deductible _____
Copay _____
Patient Percentage _____
Household Mailing Yes No
Doctor Number _____
Maximum Charges _____
Max Charge per Day _____
Maximum Visits _____
Max Visits Since Diag _____
Max Treatment Date _____
Full Balance _____
Patient Balance _____
Diagnosis Codes _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Benefits Primary Secondary Other
Coordination _____
Send Form To _____
Claim Type _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No
Similar Symptoms _____
Consultation Date _____
Condition Date _____

COMPANY NO. 2

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

COMPANY NO. 3

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

Patient Intake Form

For Office Use Only
Date: ____________________
Acct #: ____________________
Patient Height ______________
Patient Weight ______________
Patient BMI ______________
Patient Blood Pressure ________

Name: ______________________________________

Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language ____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ____________________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ______________________________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ______________

Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any tests, studies or medications received for this condition:

❑Tests/Studies: ____

❑Medications: ____

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: __________________

Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________

List the hospital procedures received: ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: _____ To: _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

What type of work do you do?_____

_____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?
- _____ Last Pap Date
- _____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

---

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

ACKNOWLEDGMENT FORM

Consent for purposes of Treatment, Payment and Healthcare Operations

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

I understand I have a right to review All Family Chiropractic's Notice of Privacy Practices prior to signing this document. All 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 All Family Chiropractic. The Notice of Privacy Practices for All Family Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and All Family Chiropractic's duties with respect to my protected health information.

All 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 office 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

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Name of Privacy Officer

_____

Notice of Privacy Policy provided but written acknowledgment refused.

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by All Family Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice
This office reserves the right to modify the privacy practices outlined in the Notice.

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____
Name of Patient (Print)

_____
Signature of Patient **Date**

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

_____
Office Representative **Date**

ALL FAMILY CHIROPRACTIC
2708 SOUTHWEST PARKWAY, SUITE A121
WICHITA FALLS, TX 76308
(940) 696-8184 FAX (940) 696-8187

NOTICE OF INFORMED CONSENT FOR TREATMENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to the treatment. This is called an informed consent.

A subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints has moved out of it's normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral subluxations with spinal manipulation (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping sound or clicking sensation in the area being treated.

In this office we use highly trained staff to assist the doctor with portions of your consultation, examination, x-ray, physiotherapy, traction, massage, exercise instruction, etc. Occasionally, when your doctor is not available another doctor will treat you in her place.

Stroke: Stroke is the most serious problem associated with spinal adjustments, regardless of whether the provider is a chiropractor or medical physician. A stroke occurs when a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with a rarer complication of death. Spinal adjustments have only been associated with strokes that arise from the vertebral artery. The specific neck adjustment that is related to this complication is never performed in this office. The most recent studies (Journal of the California Chiropractic Association Vol. 37, No 26-93) estimates that the incidence of this type of complication occurs in 1 (one) in every 3,000,000 (three million) adjustments to the neck. This means that the average chiropractor would have to practice over 100 years before they would be statistically associated with a single patient stroke.

The most effective method of lessening the odds that a patient is prone to a stroke is through careful screening of risk factors in the history, including medications taken is a family history, high blood pressure and specific exam procedures to assess blood flow to the brain.

Disc Herniation: Disc herniations that create pressure on nerves or the spinal cord are frequently treated successfully by chiropractors using adjustments, distraction and other therapies. This includes both in the neck and the low back. Yet, occasionally chiropractic treatment will aggravate this problem. To help prevent this, patients are put through specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Because of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, etc. may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution, with no long-term effects to the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle back. They extend from your back to the front of the chest. Rarely, a chiropractic adjustment may break a rib; this is referred to as a fracture. This occurs only to those patients who have weakened bones from such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. This can be ruled out in the history or x-rays. We adjust all patients carefully and especially those with bone weakened conditions. This problem occurs so rarely that there are no statistics available to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is a temporary increase of skin pain and possibly some blistering. These problems occur so rarely that there are no statistics to determine their probability.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, etc. to result in a temporary increase in soreness in the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell the doctor or a staff member about it.

Other Problems: There may be other problems or complications that may arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we can not promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care that we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

If you have any questions on the above information, please ask your doctor to explain them more fully. When you have a full understanding of this material please sign and date this document below and then return it to the front desk or the doctor.

_____ _____/_____/_____

Patient's Signature Date

_____ _____

Patient's Name Parent or Guardian's Signature

_____ _____/_____/_____

Witness Date

ALL FAMILY CHIROPRACTIC
2708 SOUTHWEST PARKWAY, SUITE A121
WICHITA FALLS, TX 76308

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. **All charges incurred are your responsibility.**

Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office **DOES NOT** guarantee your insurance policy or payments.
2. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.
3. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.
4. If your insurance company requires their own claim form(s), you are required to bring in the completed form(s) by your second visit and then as needed.
5. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.
6. Your insurance should pay within 60 days from the date in which it was filed.
7. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.
8. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office *within 48 hours*.
9. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.
10. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignments.
I realize that I am responsible for all charges incurred by me at this office.

_____ _____
Signature Date

_____ _____
Witness Date

All Family Chiropractic
2708 Southwest Pkwy – Ste A121
Wichita Falls, TX 76308
(940)696-8184

PLEASE READ CAREFULLY !

IMPORTANT MESSAGE REGARDING YOUR INSURANCE

Thank you for choosing All Family Chiropractic. Our patients are our number one priority and we want to make your visits here as pleasant as possible. We make every attempt to accommodate our patients to the fullest extent regarding insurance, however, you must realize that the insurance policy is a contract between you and your insurance company.

When presented with an insurance card, our staff will call your insurance company to verify benefits. To ease the financial burden of our patients, it is the clinic's policy to collect at the time services are rendered only the coinsurance or copay amount in addition to any remaining deductible that must be met. Please understand that benefits can be misquoted by your insurance company and the verification process is not a guarantee that payments will be made. **Ultimately the patient is responsible for any charges incurred while receiving treatment at All Family Chiropractic.**

The clinic will run two separate balances. You will see an insurance balance on your receipt, which is the amount we are waiting for your insurance company to pay. There is also a patient balance, which is what is due from the patient. In the event that your insurance company does not pay a claim in full, the balance, less any contracted write-offs, is transferred from the insurance balance to the patient balance. **That amount is expected at the time the next service is rendered, or shortly thereafter.**

Should you have any questions regarding your bill or your insurance, please do not hesitate to speak with our insurance representative. Thank you in advance for your cooperation regarding our financial policy.

I have read the information regarding the filing of my insurance claims. I understand and agree to abide by this financial policy.

_____ _____

Signature of Patient or Responsible Party Date