Electronic Health Records Update

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth_____

Address:_____ City:_____ State:_____ Zip:_____

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

E-Mail Address: _____ Would like email or text message reminders of your appointment? Y N

Social Security #:_____ Age:_____ ❒ Male ❒ Female Which? Text Email

Marital Status: ❒Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed

Your Occupation: _____ Your Employer: _____

Name Emergency Contact:_____ Phone:_____ Relationship: _____

Referred to this Office by: ❒ Friend/Family Member – Name?_____

❒ Facebook ❒ Yellow Pages ❒ Internet ❒ Clinic Location ❒ Other:_____

INSURANCE - ❒ OR **CASH-** ❒

Name of Insurance Co:_____ Ins'd Employer:_____ Ins'd SSN:_____ Ins'd DOB:_____

Do you have a secondary insurance? ❒ Yes ❒ No Name of Ins. Co:_____

MEDICAL / FAMILY HISTORY (Please indicate which conditions have been experienced by marking appropriate boxes)

	Self	Mother	Father	Brother	Sister	Children		Self	Mother	Father	Brother	Sister	Children		Self	Mother	Father	Brother	Sister	Children
AIDS							Cancer Type:____							High Blood Pressure						
Anemia							Chest Pain							High Cholesterol						
Anxiety							Concussion							Immune Disorders						
Arthritis Osteo/Rheumatoid							Diabetes							Kidney Disorders						
Asthma							Epilepsy							Memory Disorders						
Auto Immune Disorder _____							Fibromyalgia							Osteoporosis						
Back/Neck Pain							Glaucoma							Poor Circulation						
Bladder Disorders							Headaches							PTSD						
Blood Disorders							Heart Trouble							Thyroid Disorders						
Breathing Disorders _____							Hepatitis													

Name of Primary Care Doctor: _____ Describe the Condition: _____

Last Physical Exam:_____ Are you pregnant? ❒ Yes ❒ No (Due Date?_____) Any Metal Implants? ❒ Yes ❒No

MEDICATIONS	**DOSAGE/FREQUENCY**

ALLERGIES	**REACTION**

SURGERIES	**Date of Surgery**

Please describe past major injuries/broken bones:

_____

_____

_____

--OVER – Need to sign HIPAA –

Acknowledgement for 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 Family Chiropractic Clinic, P.C. or may be 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 you 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.

By my signature below I give my permission to use and disclose my health information.
I, the parent/Guardian, authorize Family Chiropractic Clinic P.C. to treat the minor listed above. ❒

Patient/Guardian Signature: _____ Date: _____

I hereby consent and state my preference to have my physician, Dr. Adkins and staff at Family Chiropractic Clinic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but not limited to, test results, appointments, and billing. I understand that email and text messaging are not confidential methods of communication and may be insecure. I understand that there is a risk that email and text messaging regarding my medical care might be intercepted and read by a third party. **Please select and initial your choice of the following communication options below.**

I, _____, give my permission to leave both appointment reminders **AND** my private health information at the following (please fill-in the ones you agree to): Initials: _____

Phone number_____ Text_____ Email _____

I, _____, give permission to contact me, relative to appointment reminders **ONLY**, by the following methods: Initials: _____

Phone message at the following number_____ Text messages at the following phone number_____
Email messages at the following email address_____

YOU MAY BE CHARGED $35 FOR MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT A 24 HOUR ADVANCED NOTICE!!

FOR OFFICE USE ONLY!!!						
Height		BP		Alcohol	Y / N	#/Day
Weight		Pulse		Tobacco	Y / N	Pk/Day