DYER CHIROPRACTIC CLINIC
33 East County Line Road, Greenwood, IN 46143
www.DyerChiropractic.com
Phone (317) 882-4922 Fax (317) 882-4898

New Patient Health History

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment.
All information is strictly CONFIDENTIAL.

Date:_____

Patient Information

Patient Name_____ Male___ Female___ Referred by_____

Street_____ City_____ State_____ ZIP_____

Telephone (work)_____(ext.)_____ (home)_____ (mobile)_____

Best time and place to reach you: _____ Email _____

Age_____ Birth Date _____/____/_____ SSN_____-_____-_____ Ages of children, if any_____

Occupation_____ Employer_____

Employer's Address_____ Marital Status_____

Spouse Information

Name_____ Birth Date _____/____/_____ SSN_____-_____-_____

Phone_____ Occupation_____ Employer _____

Current Health Complaints

Nature of Injury ___Automobile* ____Work ____Other Please describe _____

_____

Date of Injury ____-____-____ Date Symptoms Appeared ____-____-____

Have you ever had the same condition? ____Yes ____No If yes, when? _____

List of practitioners seen for this injury/condition_____

Have you ever been under chiropractic care? ____Yes ____No

If yes, please describe _____

Insurance Information

Name of party responsible for payment_____ Phone_____

Relationship to patient_____

Do you have health insurance? ____Yes ____No Name of Company_____

*If an auto accident, please provide:

Insurance Co. Name_____ Contact Person_____

Phone_____ Claim No._____

Billing

Name of Insured_____. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature_____ Date_____

Spouse's or guardian's signature_____ Date_____

Emergency Info

Emergency Contact_____ Relationship_____ Phone_____

Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had surgery?	☐	☐	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

_____

_____

_____

Have you ever suffered from:

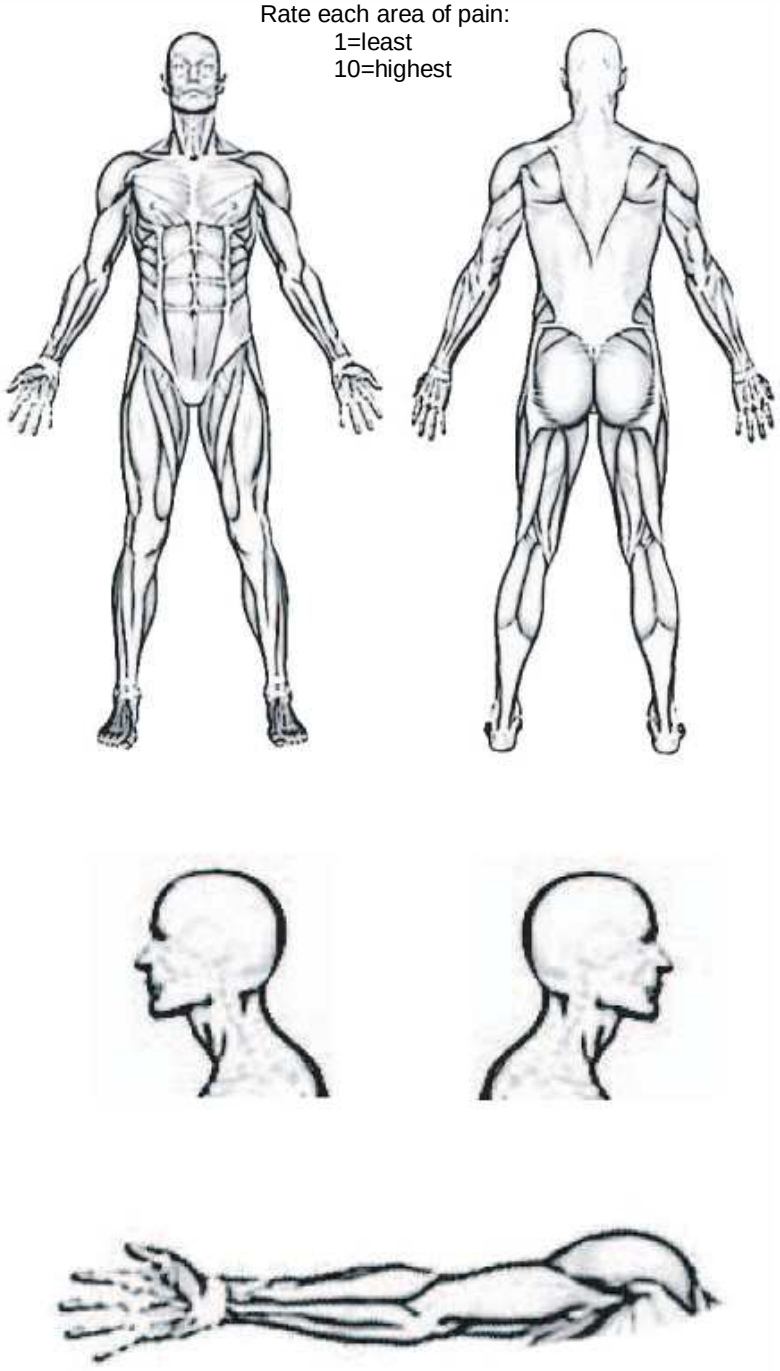
- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma ☐
- Back Pain ☐
- Breast lump ☐
- Bronchitis ☐
- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heart Beat ☐
- Irregular Cycle ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of memory ☐
- Loss of balance ☐
- Loss of smell ☐
- Loss of taste ☐
- Lumps In Breast ☐
- Neck Pain or Stiffness ☐
- Nervousness ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of breath ☐
- Sinus Infection ☐
- Sleep problems/insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other: ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing

Rate each area of pain:
1=least
10=highest



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Name: _____ Date: _____

Please list any and all doctors seen in the last two years:

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

_____

_____

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

_____

_____

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

_____

_____

(Please print this form again if you need more space)

Patient fill out bottom box only

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PATIENT REQUEST FOR RECORDS

For office use only:

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____

I hereby authorize the release of: _____ All Medical records
_____ X-rays
_____ Blood work results
_____ MRI results
_____ Other _____
_____

_____ Please **MAIL** records to**:** ___ **Dyer Chiropractic Clinic**
33 East County Line Rd
or **Greenwood, IN 46143**

_____ Please **FAX** records to: ___ **FAX: 317-882-4898**

Patient please fill out this section:

Patient's Printed Name: _____

Birthdate: _____ Social Security Number: _____

Patient's Signature: _____

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Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

I hereby instruct and direct the _____Insurance Company to pay by check made out and mailed directly to:

DYER CHIROPRACTIC CLINIC
33 East County Line Road
Greenwood, IN 46143

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

33 East County Line Road
Greenwood, IN 46143

The professional or chiropractic expense benefits allowable and otherwise payable to me under my current insurance policy are payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated this _____day of _____, 20____.

_____ _____
Signature of Policyholder Signature of Claimant, if other than Policyholder

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Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other then your home or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the “Notice Of Privacy Practices” binder in reception or ask for a copy at the Front Desk.

Name (print)	Signature	Date

If you are a minor, or if you are being represented by another party:

Personal Representative Name (Print)	Personal Representative Signature	Date