



IDEAL SPINE HEALTH CENTER

New PATIENT APPLICATION

WELCOME TO OUR CLINIC!

Welcome and thank you for applying as a patient to our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health even when many other systems may have failed. Due to the unique nature of our clinic, we may not accept you as a patient until we are certain that we know the cause of your condition and are able to establish an optimal rehab program specifically for you to help you recover your health. Please understand that if we accept you as a new patient, your health will need to be YOUR top priority as well as ours. At this point, specific recommendations will be tailored to your individual needs.

Thank you again for applying as a patient in our clinic.

Patient Signature: _____

Date: _____

NEW PATIENT APPLICATION

Full Name: _____ Nickname : _____ Age _____ Gender: [] M [] F
Home Street Address: _____ Home Phone: (_____) _____
City, State, Zip: _____ Work Phone: (_____) _____
Email Address: _____ Mobile Phone: (_____) _____
Birth Date: ____ / ____ / ____ Social Security #: _____ Marital Status: S M D W
Height ____ Weight ____ Race/Ethnicity: [] African American [] Arabic [] Asian [] Caucasian [] Hispanic [] Native Am.
Do you consider yourself to be: [] Normal Weight [] Underweight [] Overweight [] Obese [] Extremely Obese
Primary Spoken Language: _____ How were you referred to this office? _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Spouse Work Phone: (_____) _____ Spouse Mobile: (_____) _____
Spouse's Employer: _____ Occupation: _____

PURPOSE OF VISIT

| Reasons for appointment: | Date condition started: | Have you had this before? | Injury related? |
|--------------------------|-------------------------|---------------------------|-----------------|
| 1. _____ | _____ | [] Yes [] No | [] Yes [] No |
| 2. _____ | _____ | [] Yes [] No | [] Yes [] No |
| 3. _____ | _____ | [] Yes [] No | [] Yes [] No |

EXPERIENCE WITH STANDARD CHIROPRACTIC

Have you seen a Chiropractor before? [] Yes [] No Who? _____
When? _____ Reason for visits? _____
How did you respond? _____
Did your previous chiropractor take before and after X-rays? [] Yes [] No
Did your previous chiropractor tell you that poor posture can negatively affect your overall health? [] Yes [] No
Did your previous chiropractor make you aware of any of your poor posture habits? [] Yes [] No
Explain: _____
Are you aware of any poor posture habits in your spouse or children? [] Yes [] No
Explain: _____

OTHER PROVIDERS

Medical Doctors Seen:
Name: _____ Date of last visit: _____ Is this your primary care provider? [] Yes [] No
Would you like us to forward our findings and recommendations to this physician? [] Yes [] No
Name: _____ Date of last visit: _____ Is this your primary care provider? [] Yes [] No
Would you like us to forward our findings and recommendations to this physician? [] Yes [] No
Name: _____ Date of last visit: _____ Is this your primary care provider? [] Yes [] No
Would you like us to forward our findings and recommendations to this physician? [] Yes [] No

Previous surgeries (all types) and dates: _____

What other testing or treatments have you tried to date for present condition with location (facility) and dates of those tests and treatments: _____

Current over-the-counter medications: _____

Current prescription medications: _____

SOCIAL HISTORY AND LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming
 Other _____

Do you consider yourself to be...? Underweight Normal weight Overweight Obese Severely obese

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____ per day week Month Year

Do you drink coffee? Yes No How many cups per day? _____

What supplements do you take (i.e. vitamins, minerals, herbs)? _____

FAMILY HEALTH HISTORY

Have any of your biological family members ever been diagnosed with the following:

| | | | | |
|--|---|---|---|------------------------------------|
| <input type="checkbox"/> Mental Health Disease | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Immune System Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Broken Bones/Fractures | |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Other: _____ | | |

| Family History | Present Age(s) | Age(s) at Death | Medical Problems / Cause(s) of Death |
|----------------|----------------|-----------------|--------------------------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ |
| Son / Daughter | _____ | _____ | _____ |
| Son / Daughter | _____ | _____ | _____ |
| Son / Daughter | _____ | _____ | _____ |
| Son / Daughter | _____ | _____ | _____ |

🍏 Please check here if you were adopted and this does not apply to you.

FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care? YES NO Referred out:

Doctor's Signature: _____ Date: _____



IDEAL SPINE

HEALTH CENTER

New PATIENT APPLICATION—CONSENT FORMS

RADIOGRAPH CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Ideal Spine Health Center, PLLC and/or his associates and assistants to take spine or other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Signature of Patient/or Guardian: _____ Date: _____

ALL FEMALES: I also hereby declare to my knowledge that I am not pregnant _____.
Initial _____

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use of spinal adjustments and rehabilitative exercises, traction and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The doctor and/or assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or assistants specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Signature of Patient/or Guardian

Date

IN CASE OF EMERGENCY

Name _____ Relationship _____

Work Phone (_____) _____ Home Phone (_____) _____ Cell Phone (_____) _____

INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? Yes No Policy# _____ Group # _____

Insurance Co. Name _____ Phone # _____

Address _____

Insured's Name _____ Birth date: ____/____/____ Relationship _____

For Automobile Accidents, what is the name of your Insurance Carrier? _____

Phone # _____ Policy Claim Number: _____

For Work Injury, what is your Employer Contact Name _____ Phone # _____

Claim No _____ If known, Insurance Carrier? _____

Other than yourself, who else should receive charges on your account? (CHECK ALL THAT APPLY)

Spouse Parent/Guardian Workers Comp Auto Insurance Medicare Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier this is done strictly as a convenience and courtesy for me. (We will only bill the insurance one time for a Date of Service at no charge to the patient.) This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I authorize the assignment of all insurance benefits be directed to Ideal Spine Health Center, PLLC, its associated doctors and/or assistants for all services rendered. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services. I understand that in the case of worker's compensation, personal injury or other case where legal settlement is involved, if an insurance company issues a check for services received to either me, the patient, my legal guardian or to someone representing me such as an attorney, I am responsible for payment of bills in full within 14 days.

I also understand that I will be charged \$25 for any and all scheduled appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian: _____ Date: _____

HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES IDEAL SPINE HEALTH CENTER, PLLC AND ASSOCIATES TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Ideal Spine Health Center, PLLC and Associates to use my name, address, phone numbers, photo and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Ideal Spine Health Center, PLLC and Associates to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving Ideal Spine Health Center, PLLC and Associates permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

- * The right to review the notice prior to signing this consent.
- * The right to object to the use of my health care information for directory purpose.
- * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian: _____ Date: _____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable, benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Relationship to patient

Patient or legal Guardian Signature

Date

Witness Signature (office staff)

Date