Morris Chiropractic Clinic

Patient Information

Date: _____ Patient Name_____ Patient #_____

☐ Male ☐ Female _____ Home phone_____

E-Mail _____ Date of Birth:_____ Cell Phone _____

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Address _____City _____ State_____ Zip_____

Business Address _____ City _____ state _____ Zip _____

Spouse or parent/guardian's name_____ Employer_____ work phone_____

Business Address_____City_____State_____Zip_____

Spouse or Parent/Guardian's name_____ Employer _____ Work Phone_____

Patient's or parent/guardian's employer _____ work phone _____

If Patient is a student, name of school/college_____City_____State_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Employer _____Work Phone_____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any additional insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Date employed_____

Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip/P.C_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

How much is your deductible? _____ how much have you used? _____

Assignment and Release

I understand and agree that (regardless of whatever health insurance or medical benefit I have). I am ultimately responsible to pay **Morris Chiropractic Clinic.** The balance due on my account. For any professional services rendered and for any supplies, test, or medications provided. I herby authorize payment of any health insurance or medical plan benefits directly to **Morris Chiropractic Clinic** for medical services rendered and for any supplies, test, or medications provided. I herby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that are needed to file and process insurance or medical plan claims to pursue appeals on any denied or partially denied claims. For legal pursuit as to any unpaid or partially paid claims or to pursue any other remedies necessary in connection with same. I herby assign directly to **Morris Chiropractic Clinic.** All rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy/policies. This assignment includes, but is not limited to, a designation that **Morris Chiropractic Clinic can** act on my behalf, as our representative or ERISA representative, as to any initial claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **Morris Chiropractic Clinic** and to pursue any and all remedies to which I/we may be initialed, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and photocopy is to be considered as valid enforceable as the original.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of Patient or parent/guardian of minor **Date**

Last Name First Name M.I. Date

PLEASE CIRCLE THE SYMPTOMS YOU NOW HAVE OR HAVE HAD RECENTLY. YOUR HEALTH REPORT IS CONFIDENTIAL AND IS TREATED AS SUCH BY OUR STAFF.

Headaches
Where _____
Dizziness
Fainting
Loss of Balance
Weakness
Slurred speech
Blurred vision
Double vision
Ringing in ears
Nausea/vomiting
Numbness
Where _____

Shortness of Breath
Chest pain
Arm pain
Fatigue
Rapid heart beat
Excessive sweating
Palpitations
Poor circulation
Swollen joints

Wheezing
Cough/phlegm
Cough/blood

Eye Pain
Deafness
Ear pain
Hoarseness
Weight gain
Weight loss
Abdominal pain
Constipation
Diarrhea
Belching gas
Stool changes
Rectal bleeding
Fever

Incontinence
Painful urination
Frequent urination
Excessive thirst
Discolored urine
Problems voiding
Menstrual problem

Alteration of:
skin temperature
skin color
Enlarged glands
Loss of memory

Please describe your pain and its location:

_____

_____

Frequency of episodes: _____

Prior treatment for present condition: _____

Prior studies (please circle): X-rays/MRI/CT/Sonogram/Other:

Have you had any of the following: (Please Circle)

CVA/Stroke
Mental disorder
Paralysis
Tremors
Epilepsy
Thyroid problems
Lung disease
Heart disease
Rheumatic fever
Diabetes

Heart Murmur
Colitis
Cirrhosis/Hepatitis
Venereal disease
Alcoholism
Drug addiction
Gall bladder disease
Diverticulosis
Kidney stone

AIDS/HIV
Polio
High blood pressure
Scoliosis
Hernia
Psoriasis
Anemia
Arthritis
Type:
Cancer:
Type:

Allergies:

Please list any other serious medical conditions you have or have ever had:

Fracture/Joint Replacements (area and date):

Surgery (area and date):

Car accidents (date):

Serious accidents (date):

Hospitalizations (date):

Are you presently being treated for any other condition?
Yes_____ No_____ If yes, by whom_____for _____

Family History:	*Condition/Disease*	*Alive*	*Deceased*
Mother			
Father			
Siblings			

Please tell us how much of the following you have or do per day:

Tobacco _____packs/day *Alcohol____servings/day* *Coffee_____cups/day*

Sleep_____hours/day *Exercise____/day* *Appetite____meals/day*

*Vitamins/Supplements:*_____

*Drugs/Medications:*_____

*Sports or Activities:*_____

*Remarks/Comments:*_____

Known Allergies:

Signature _____ *Date* _____

Revised: 3-24-17

Morris
CHIROPRACTIC

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician/physician's assistant. The chiropractic physician/physician assistant provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by the physicians at Morris Chiropractic, I am authorizing them to proceed with any chiropractic/medical treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic/medical treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge (I am / am NOT pregnant) and (give my permission / don't give my permission) to x-ray me for diagnostic interpretation.
(Please circle one) (Please circle one)

Missed Appointments:

There is a possible $20 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic/medical care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]
May we send appointment reminders by text message or e-mail? Yes ( ) No ( )
Please provide your e-mail address or phone number and cell carrier for text messaging:

_____

I, _____, have read and fully understand the above statements.

Acknowledgement

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____ Signature: _____ Date: _____

Revised: 6-11-2020

MORRIS CHIROPRACTIC CLINIC
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic x-rays, where warranted, on me **(or on the patient named below for whom I am legally responsible)**, by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, it's the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: Increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and Procedures: Additional pain and discomfort. Endurance exercise may cause increased risk of acute myocardial infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition andn for any future condition (s) for which I seek treatment.

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

Witness Signature:_____ **Date** _____

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