



Basic Information

Name _____ Age _____ Date _____
Your SS# _____ Your Birthdate _____ Marital Status S M D W
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____
Occupation _____ #Years _____ Employer _____
Employer's Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Spouse's Employer _____
Spouse's Social Security Number _____ Spouse's Birthdate _____

Insurance Company _____ Policy # _____
Whose policy is it? _____ Group # _____
Insurance Company Phone _____

I hereby instruct and direct my insurance company (listed above) to pay Fink Family Chiropractic directly for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signed _____ Date _____

Who referred you to this clinic? _____
In Case of Emergency Contact _____ Phone _____

Medical History

Are you currently taking any medications? (If yes, please explain) _____

Have you had any surgeries? (If yes, please explain) _____

Have you ever broken a bone? (If yes, please explain) _____

Do you suffer from... (check all that apply) Addiction Arthritis or Gout Cancer Diabetes
 Heart disease High Blood Pressure Kidney Disease Tuberculosis

Are there any other current diagnosed health conditions not covered above? (If yes, please explain) _____

I have completed the above medical history information to the best of my ability.

Signed _____ Date _____

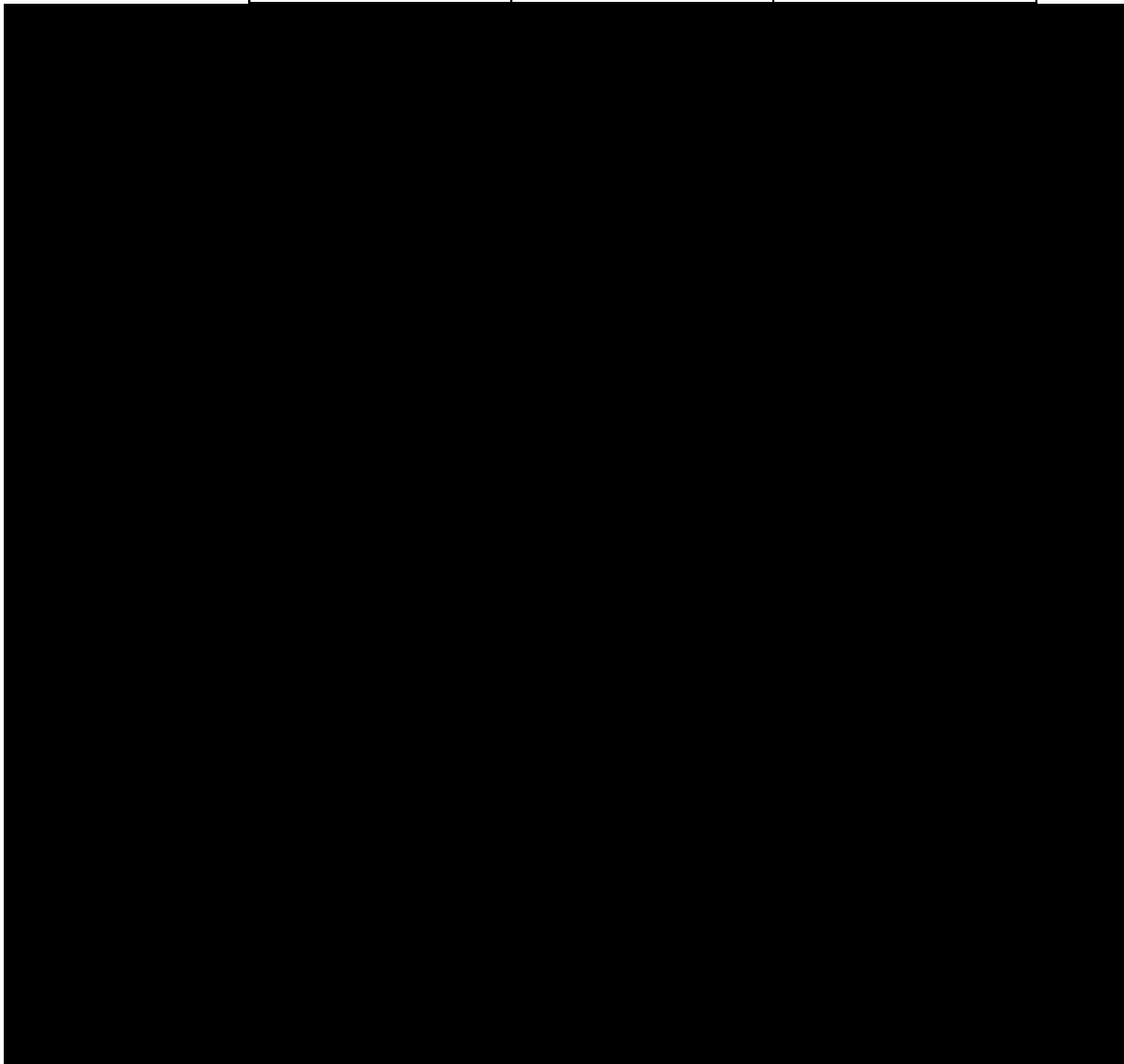


PAIN DRAWING

Patient Name _____ Date _____

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT		
A = A CHE	B = B URNING	C = S TABBING
N = N UMBING	P = P INS & NEEDLES	O = O THER



**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, Fink Family Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with a *Notice of Privacy Policies* that provides a complete description of information uses/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 information for directory purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Fink Family Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Fink Family Chiropractic reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Fink Family Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this practice's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____
 Consent refused by patient, and treatment refused as permitted.
 Consent added to the patient's medical record on _____