



# JACKSONVILLE CHIROPRACTIC

1727 T. P. White Drive · Jacksonville, AR 72076 · (501) 985-7711 · www.drblakebennett.com

## PATIENT INFORMATION

Legal Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female  
 Address \_\_\_\_\_  Apt#  Lot# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
 Race \_\_\_\_\_  I Decline to answer Ethnicity \_\_\_\_\_  I Decline to answer  
 Preferred Language:  English  Other: \_\_\_\_\_ Patient Reminders by: (check one)  
 email  phone  mail  
 Patient SSN# \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Spouse's SSN# \_\_\_\_\_  
 How were you referred to our office : \_\_\_\_\_

## PHONE NUMBERS & EMAIL

Home ( ) \_\_\_\_\_ Email Address \_\_\_\_\_  
 Cell ( ) \_\_\_\_\_ Best time to reach you \_\_\_\_\_  AM  PM  
 Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

### EMERGENCY CONTACT:

Name \_\_\_\_\_ Home ( ) \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
 Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Is patient covered by Secondary Insurance Co.?  Yes  No  
 Name of Secondary Insurance Co \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

## PATIENT CONDITION

Where is your pain (discomfort)? \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

What caused your condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain as of **right now**:  No Pain  1  2  3  4  
 5  6  7  8  9  10

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Stiffness  Swelling  Other: \_\_\_\_\_

How often do you have the pain?  Constant  Daily  Weekly  Monthly

Other: \_\_\_\_\_

What activities or movements make it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

My symptoms are interfering with my:  Work  Sleep  Daily Routine  Recreation

Was this condition due to an accident?  Yes  No

If Yes, Date of Accident? \_\_\_\_\_

Type of Accident:  Auto  Work  Home  Other: \_\_\_\_\_

Do you have an attorney for this accident?  Yes  No

If Yes, name of Attorney: \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

Firm Name: \_\_\_\_\_

## HEALTH HISTORY

Have you seen a Chiropractor before?  No  Yes: If yes, date of last adjustment: \_\_\_\_\_

What treatment have you received for **this condition**? \_\_\_\_\_

Other Doctors seen for **this condition**: \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal Exam \_\_\_\_\_

Spinal X-Ray \_\_\_\_\_ MRI, CT, Bone Scan \_\_\_\_\_

List any other conditions that we should be made aware of regarding your health :  
(Pregnancy, High Blood Pressure, Diabetes, Cancer, etc.) \_\_\_\_\_

**Exercise:** Type: (ex.: treadmill, yoga, etc.) \_\_\_\_\_ Duration: \_\_\_\_\_

**Work Activity:**  Sitting  Standing  Light Labor  Heavy Labor

### Habits:

Caffeine Drinks How many: \_\_\_\_\_ Every:  Day  Week  Month

Alcohol How many: \_\_\_\_\_ Every:  Day  Week  Month

High Stress Reason(s): \_\_\_\_\_

Smoking Status:  Never Smoked  Former Smoker  Occasional Smoker  Every Day Smoker

If "Occasional" or "Every Day": How many  Cigarettes  Pack(s) **OR**  Cigars **a day?** \_\_\_\_\_

**SURGERIES & INJURIES**

Surgeries	Date	Injuries	Date

**MEDICATIONS**

Are you currently taking any medications?  Yes  No

Medication Name	Dosage (i.e. 5mg)	Frequency (i.e. once a day)

Do you have any *medication* allergies?  Yes  No

Medication Name	Reaction (i.e. nausea, etc.)	Onset Date

## FAMILY MEDICAL HISTORY

**Unknown**

Diagnosis	Father	Mother	Brother	Sister	Son	Daughter
<i>Example: Heart Disease</i>		X				

Is there anything else you would like us to know that would help us help you?    No    Yes:

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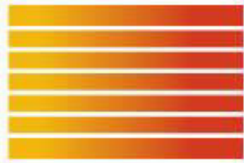
**I choose to decline receipt of my clinical summary after every visit. *(This is not your receipt of payment.)***  
*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with the named insurance company on page one and assign directly to Dr. Blake Bennett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. By signing below I am stating that All the information that is on this eight page form is true.

Date \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_



## Patient Privacy

**May we have your permission for the following:**

**1. May we leave messages regarding appointments on your voicemail?**

- |                                     |            |           |
|-------------------------------------|------------|-----------|
| <input type="checkbox"/> Home Phone | <b>Yes</b> | <b>No</b> |
| <input type="checkbox"/> Cell Phone | <b>Yes</b> | <b>No</b> |
| <input type="checkbox"/> Work Phone | <b>Yes</b> | <b>No</b> |

**2. May we leave a message with anyone?      Yes      No**

Name of designated individuals	Relationship to you
_____	_____
_____	_____
_____	_____

**3. Do we have permission to use your email?**

We sometimes use email to send condition specific information, reply back to your questions, or alert scheduled patients of office closure (snow days, electricity is out, etc).      **Yes      No**

**4. Do you want anyone to have access to all of your health records?      Yes      No**  
(Includes: treatment plan, appointment dates and times.)

Name of designated individuals	Relationship to you
_____	_____
_____	_____
_____	_____

I, \_\_\_\_\_, have given Jacksonville Chiropractic, P.A. my answers on how I want my privacy to be protected.

\_\_\_\_\_  
Patient's (Legal Guardian's) Signature

\_\_\_\_\_  
Date



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## 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 Jacksonville Chiropractic, PA 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. I have received a copy of the Notice of Patient Privacy Policy. \_\_\_\_\_ Patient Initials

### Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your 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.

### Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

### 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.***  
*(this could include information for second opinions, reading X-Rays, fill-in doctors, or emergency situations.  
Any release of records/charts would require additional notification and your signature)*

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



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## FINANCIAL ARRANGEMENT POLICY

Thank you for choosing us for your health care needs. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. We require you to read and sign the following statement prior to any treatment.

- All patients must complete our Patient Information form prior to seeing the doctor. To allow us to provide the highest quality care please complete these forms as accurately as possible.
- Payment of deductible, co-payment, co-insurance amount, and any non-covered service is **due at the time of service**.
- Non-insured patients are expected to pay in full at the time of service.
- Understand that payment of your bill is considered part of your treatment.

\*\*We accept cash, personal checks, Care Credit Health Card, and all four major credit cards.

### Insurances

With the exception of Medicare, Medicaid, and Managed Care Organizations with which we participate, your insurance coverage is a contract between you and your insurance company. We are not a party to that contract, but we will help you to receive maximum benefits. We file claims as a courtesy to our patients, however, you are responsible for paying all deductibles, co-payments, co-insurance amounts, and non-covered services at the time of service.

### Usual and Customary Rates

Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We **will not** become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, etc., other than to file and provide factual information as necessary. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.**

If you have any questions regarding our fees, financial policy or your responsibilities please let us know.

**Patients without insurance coverage** are expected to pay for services at time of service.

**Patients with insurance coverage** are expected to pay any deductible, co-payments, co-insurance amounts, and non-covered services at time of service.

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SIGN (Patient, or parent if minor)

**AUTHORIZATION** to check claim status: I hereby authorize Jacksonville Chiropractic Clinic to obtain the status of my claim(s).

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SIGN (Patient, or parent if minor)

**AUTHORIZATION** to pay benefits to physician: I hereby authorize payment directly to Jacksonville Chiropractic Clinic, for chiropractic benefits.

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SIGN (Patient, or parent if minor)

Date \_\_\_\_\_



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## Informed Consent

The information I have given this office is complete and true to the best of my knowledge.

I authorize Dr. Blake Bennett, or any other licensed chiropractors at Jacksonville Chiropractic Clinic, or staff, to perform an examination for the purpose of detecting spinal subluxations. Chiropractors are not internal specialists, and every patient should be mindful of his or her symptoms and secure other medical opinions if he or she has any concern for their total condition. Your examination may also include X-rays.

I also authorize Dr. Bennett, or any other licensed chiropractor at Jacksonville Chiropractic Clinic, or staff, to administer treatment and procedures as they deem necessary. Any question that I may have regarding my condition and treatment has been or will be answered before treatment is administered. The doctor and staff have implied no guarantee of cure.

If patient is considered a minor the parent or guardian's signature is needed which consents examination and treatment of the child under the statements said above. This signature also implies that the parent or guardian does not have to be present at all treatment dates.

Patient's Name (print) \_\_\_\_\_

Patient's (or Legal Guardian's if minor) Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## For Women Only

I have been advised by the doctor or staff member of Jacksonville Chiropractic Clinic that X-rays can be hazardous to an unborn child. If I am not pregnant then I consent to having an X-Ray taken if needed. If I am or might be pregnant an X-Ray will not be taken.

I am **not** pregnant.  I **might be** pregnant  I **am** pregnant. Due Date: \_\_\_\_\_

Patient's Name (print) \_\_\_\_\_

Patient's (or Guardian's if minor) Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_