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

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. _____

AUTO INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Name of person who is at fault: _____ Birth Date _____
Policy Holder's Name: _____ Birth Date _____
Auto Insurance Co. _____ Claim # _____
Claim Adjuster's Name _____ Phone ( ) _____

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
Example: Heart Disease		*X*				

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

□ 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 understand that I am financially responsible for all charges whether or not paid by my insurance, third party insurance, or Attorney. 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

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AUTO ACCIDENT QUESTIONNAIRE

Patient's Name: _____ Patient # _____

INJURY HISTORY

Date of injury: _____ Was the accident on the job? ☐ Yes ☐ No

The vehicle you were in:

You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger
☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other: _____

Vehicle driven by: _____

Year: _____ Make: _____ Model: _____

Were you: ☐ Stopped ☐ Slowing ☐ Accelerating

Your estimated speed at moment of accident: _____ MPH

Time of Day: _____ ☐ AM ☐ PM

Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice

Head Rest: ☐ None ☐ Integral Type
☐ Adjustable Type: ☐ Up ☐ Down ☐ Don't Know
If adjustable, was the position altered by the accident? ☐ Yes ☐ No

Was the seat broken because of the accident? ☐ Yes ☐ No

Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know

Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know

Did air bag deploy? ☐ Yes ☐ No

Body position: ☐ Good ☐ Forward lean ☐ Other: _____

Head position: ☐ Forward ☐ Head turned left ☐ Head turned right ☐ Head up
☐ Head down ☐ Other: _____

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A

Brakes applied? ☐ Yes ☐ No

Aware of impending crash? ☐ Yes ☐ No

Accident Description: _____

_____

_____

Did your body strike any parts of the vehicle? ☐ Yes ☐ No

If yes, describe: _____

Did vehicle strike any objects after crash? ☐ Yes ☐ No

If yes, describe: _____

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____

AFTER THE ACCIDENT

Symptoms: ☐ Headache ☐ Dizziness ☐ Confusion/Disorientation ☐ Neck pain
☐ Low Back pain ☐ Paresthesia ☐ Nausea ☐ Other

If yes, or Other symptoms, where? _____

Any pain in your extremities (arms, legs, etc.) ☐ Yes ☐ No

If yes, where?

When did your symptoms first appear? ☐ Immediately ☐ Hours ☐ Days

Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital

Mode of transportation: _____

TREATMENT HISTORY

Did you go to the emergency room? ☐ Yes ☐ No

If yes, state when and what hospital: _____

X-Rays: ☐ Yes ☐ No

Body parts imaged: _____

☐ Cervical Collar ☐ Ice

Medications: _____

Other treatment: _____

Follow-up instructions given: ☐ None ☐ Yes, explain: _____

_____

1. Dr.: _____

Specialty: _____ Date first seen: _____

Treatment type: _____ Treatment frequency: _____

Treatment duration: _____

Currently treating? ☐ Yes ☐ No Did treatment help? ☐ Yes ☐ No

2. Dr.: _____

Specialty: _____ Date first seen: _____

Treatment type: _____ Treatment frequency: _____

Treatment duration: _____

Currently treating? ☐ Yes ☐ No Did treatment help? ☐ Yes ☐ No

Notes: _____

_____

Do you have a Police Report? ☐ Yes ☐ No

_____ _____

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

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Patient Privacy Act

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

☐ Home Phone **Yes** **No**

☐ Cell Phone **Yes** **No**

☐ Work Phone **Yes** **No**

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

Name of designated individuals Relationship to you

_____ _____

_____ _____

3. Do we have your permission to text you? **Yes** **No**

4. 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**

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

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.
- **Third Party Claims (Auto Accidents)** where payment is usually paid at the end of treatment; a medical lien may be filed. This protects us and allows you to be treated without paying as treatment progresses.

**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.

_____
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).

_____
SIGN (Patient, or parent if minor)

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

_____
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 questions 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 Legal Guardian's if minor) Signature _____ Date _____

Witness _____ Date _____