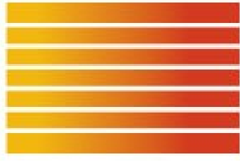

JACKSONVILLE CHIROPRACTIC

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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. ______

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:

____

____

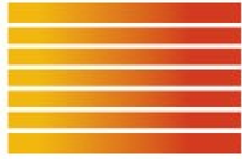
☐ **I choose to decline receipt of my clinical summary after every visit.** ***(This is not your receipt of payment.)***
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

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

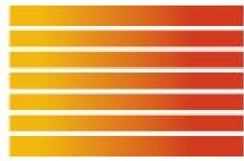
Notes: ______________________________

____

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 (answering machine)?**

   ☐ 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?**
   We do not send group texts or any solicitation through text messaging. We would only text you about your appointment or as a first level of communication if we need to contact 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?** **Yes** **No**
   (Includes: treatment plan, appointment dates and times.)

   Name of designated individuals Relationship to you

   ____________________________ ____________________________

   ____________________________ ____________________________

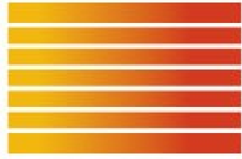
6. **Have you seen your primary care doctor for this condition in the last 3 months?** **Yes** **No**

If Yes, and you would like us to send an update, please list your PCP here: ____________________________

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.

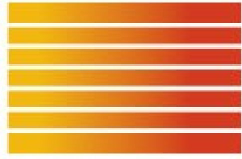
By my signature below I give my permission to use and disclose my health information.

(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)

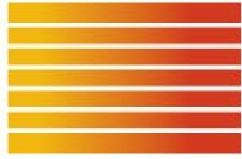
AUTHORIZATION to check claim status: I hereby authorize Jacksonville Chiropractic Clinic to obtain the status of my claim(s).

____
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 ______________________



JACKSONVILLE CHIROPRACTIC

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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 ______________