PATIENT INTRODUCTION CARD

(Please Print) Date:_____

Name:_____Social Security No.:_____

(Last) (First) (Middle)

Address:_____Phone:_____

City:_____State:_____Zip:_____

Birth date:_____Age:_____ ❑ Male ❑ Female No. of Children:_____

Occupation:_____ ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Employed by:_____Business Phone:_____

Address:_____City:_____State:_____Zip:_____

Name of spouse (or parent, if minor)_____Occupation:_____

Address:_____City:_____State:_____Zip:_____

Person responsible for account:_____

Address:_____City:_____State:_____Zip:_____

Referred by:_____

Have you had chiropractic care before?_____When?_____

Do you have health insurance?_____What company?_____

Address:_____Policy Number:_____

Subscriber's date of birth:_____Subscriber’s Social Security No.:_____

PATIENT HISTORY OUTLINE

Name:_____Date:_____

Address:_____Zip Code:_____

Telephone:_____Email:_____

Height:_____Weight:_____Sex: M:___ F:___ Married:_____Single:_____

Occupation:_____Employer:_____

Referred By:_____

Please check if you have had problems with any of the following (past or present):

___ Deafness
___ Noises in Ears
___ Choking
___ Colds or Flu
___ Lung Trouble
___ Sinus Trouble
___ Asthma
___ Shortness of Breath
___ High / Low Blood Pressure
___ Heart Trouble
___ Leg Cramps
___ Diabetic
___ Stomach Trouble
___ Indigestion
___ Colon Trouble
___ Constipation
___ Nausea
___ Joint Stiffness
___ Paralysis
___ Back Trouble
___ Arthritis
___ Skin Rash
___ Depression
___ Headaches
___ Dizziness
___ Numbness
___ Tingling
___ Exhaustion
___ Weakness
___ Poor Health
___ Trouble Sleeping
___ Nervousness
___ Crying Spells
___ Worry
___ Frequent Anger
___ Fear
___ Bad Dreams
___ Prostrate Problems
___ Kidney Trouble
___ Bladder Trouble
___ Female Trouble
___ Menstrual Cramps
___ Discharge
___ Nerve Pains

ARE YOU PREGNANT? Y N

Major Complaints:_____

_____

Position of Greatest Pain:_____

When did you first become sick, injured:_____

Accidents?_____Surgery?_____

Have you ever had Chiropractic Care before?_____ If yes, how long ago_____

How many doctors have you consulted for your present condition?_____

Results:_____

How does your present condition interfere with normal living or work?_____

_____

Do you desire? Maximum Improvement:_____ Temporary Relief:_____

TERMS OF ACCEPTANCE

When a patient seeks a chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. however, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustment to correct vertebral subluxation.

I _____ have read. and fully understand the above statements.
(Print Name)
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction,

I therefore accept chiropractic care on the basis,

_____ _____
(Signature) (Date)

Consent for Purposes of Treatment, Payment and Healthcare Operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by AGRUSA CHIROPRACTIC CENTER for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of AGRUSA CHIROPRACTIC CENTER. I understand that J. James Agrusa, D.C. may refuse to diagnose or treatment me,1 I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. That AGRUSA CHIROPRACTIC CENTER is not required to agree to the restrictions that I may request. However, if AGRUSA CHIROPRACTIC CENTER agrees to a restriction that I request, the restriction is binding on AGRUSA CHIROPRACTIC CENTER and J. JAMES AGRUSA, D.C..

I understand I have a right to review AGRUSA CHIROPRACTIC CENTER's Notice of Privacy Practices prior to signing this document. AGRUSA CHIROPRACTIC CENTER's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the perFormance of health care operations of AGRUSA CHIROPRACTIC CENTER. The Notice of Privacy Practices for AGRUSA CHIROPRACTIC CENTER is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and AGRUSA CHIROPRACTIC CENTER'S duties with respect to my protected health information. AGRUSA CHIROPRACTIC CENTER reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that AGRUSA CHIROPRACTIC CENTER or J. JAMES AGRUSA, D.C. has taken action in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority