WELCOME

one 1

ABOUT YOU

Today's Date: ____/____/____ File #: ________

Patient Name: ________________________________
LAST FIRST MI

What You Prefer To Be Called: ________ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:______ SS#: ________

Mailing Address: ________________________________

____
CITY STATE ZIP

Home Phone #: ________________________________

Work Phone #: ________________ Ext: ________

Other Phone #s: ________________________________

E-Mail Address: ________________________________

Referred By: ________________________________

Employer: ________________ How Long? ________

Employer's Address: ________________________________

____
CITY STATE ZIP

Occupation: ________________________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ________________________________

Do you have children? ❑ Yes ❑ No How many?________

two 2

INSURANCE INFO

Co. Name: ________________________________

Address: ________________________________

____
CITY STATE ZIP

Phone #: ________________________________

Insured's ID#: ________________________________

Group # (Plan, Local, or Policy #): ________________

Insured's Name: ________________________________

Relation: ________ Date of Birth: ____/____/____

Insured's Employer: ________________________________

Please inform front desk of 2nd. Insurance source.

three 3

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): ________________________________

____

Please describe the pain & its location: ________________________________

____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: ________________________________

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: ________________________________

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where?________________________________

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom?________________ Phone#:________________

PLEASE CONTINUE ON BACK

4 four

IN EVENT OF EMERGENCY

Who should we contact? ______________________________

Relation: ______________________________

Home Phone #: ________________ Work Phone #: ________________

Who is your Medical Doctor? ________________ Phone #: ________________

HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ____________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you may be allergic to: ______________________________

____

List previous surgeries/treatments with dates: ______________________________

____

List any **past** serious accidents with dates: ______________________________

____

Family Health History: ______________________________

____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: _____/_____/_____

Do you smoke? ❑ No ❑ Yes / How Much? _______ How Long? _______

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress?_____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?_____ Nursing? ❑ Yes ❑ No

5 five

6 six

ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____
CITY STATE ZIP

SSN: ______________________________

D.L.#: ______________________________

Work Phone#: ______________________________

Payment method: ❑ CASH ❑ Check

______________________________ ___/___

❑ Credit Card - Enter card # above (if accepted)

_______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

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PAIN CHART

ABOUT YOU

Name: ______________________ File #: ______________________

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..
Please describe your condition:

____

____

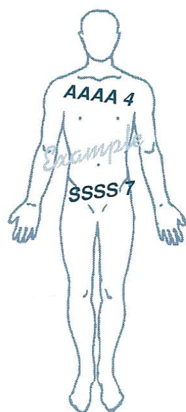
Signature: ______________________ Date: ___/___/___

SHOW US WHERE IT HURTS

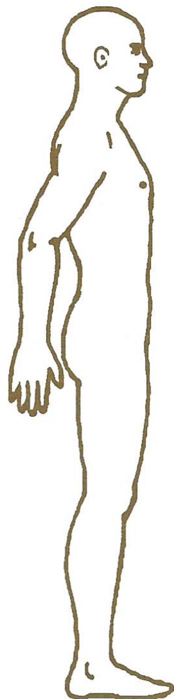
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

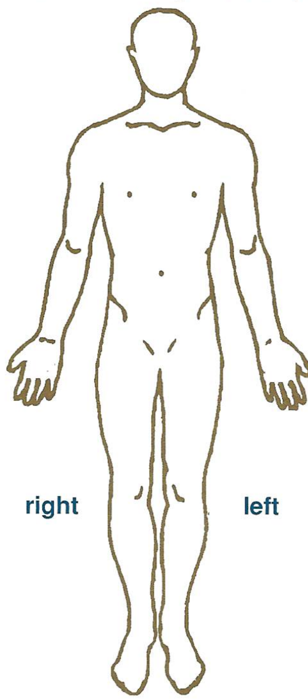
◯ Circle any area of pain not represented by a symbol.



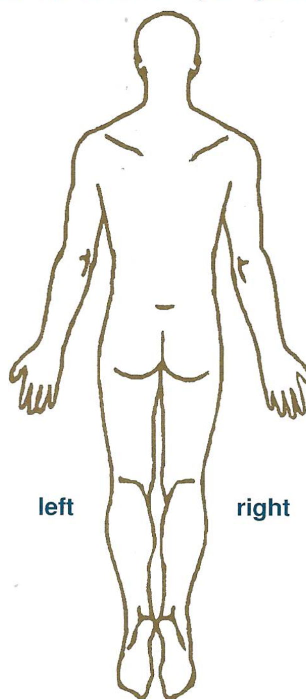
Example



Right



Front



Back

Left

DOCTOR'S NOTES

____

____

____

____

____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

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Doctor's Info

DOCTOR'S NOTES

THIS PAGE
★ FOR DOCTOR'S USE ONLY

Primary Complaint & Method of Injury:

Date of Injury:

What Aggravates your Symptoms:

What Relieves your Symptoms:

Past History & Treatment(accident/injury):

Surgeries/Hospitalized:

Current Medications/Vitamins:

Medical Doctor:

Family History:

HEIGHT

WEIGHT

BLOOD PRESSURE

PULSE

TEMP

COMMENTS:

DOCTOR'S NOTES

BLEDSOE FAMILY CHIROPRACTIC CLINIC
221 6th Avenue SE Suite #1 Aberdeen, SD 57401
605-229-1212

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____
Patient

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** ____

____

____
Staff signature **Date**

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Form may only be copied and/or customized by the owner of this book for use in his/her own office.

(All)

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr.__________________(and whomever he/she may designate as his/her assistant(s) to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature__________________________________ Date______________ Witness__________________________

(All)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature__________________________________ Date______________ Witness__________________________

(All)

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the __________________ Insurance Company / Insurance Administrator to pay by check and for it to be mailed directly to: ____________________________

____

____________________________ the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner any balance of said professional charges. I agree that this office be given power of attorney to endorse/ sign my name on any and all drafts for payment of my bill.

Patient's Signature__________________________________ Date______________ Witness__________________________

(W C/PI)

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient am directing my Attorney ______________________ to pay any outstanding bills out of my settlement, and, in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for doctor's additional protection and consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current basis.

Patient's Signature__________________________________ Date______________ Witness__________________________

CONSENT FOR TREATMENT OF MINOR

I hereby authorize ______________________________, D.C., and whomever he/she may designate as his/her assistance(s) to administer chiropractic care as he/she deems necessary to my _________________________ (indicate relationship of child).

Patient's Signature__________________________________ Date______________ Witness__________________________

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BLEDSOE FAMILY CHIROPRACTIC, LLC

Centre Pointe Plaza, Suite 1
221 Sixth Avenue SE
Aberdeen, SD 57401

Informed Consent for Chiropractic Treatment

I hereby consent to the performance of diagnostic test(s) and the administration of procedures and other chiropractic treatment in the management of my health condition(s).

Chiropractic treatment like all other medical procedures and treatment, does have an inherent (but very small) risk of bodily harm. The serious risks associated with chiropractic procedures, particularly with Chiropractic Manipulative Therapy (CMT), or spinal "adjustment" are extremely rare. Some of the known risks are identified below:

Temporary soreness or increased symptoms or pain: It is not uncommon for patients to experience temporary soreness, brief increase in symptoms, or brief increase in pain following chiropractic treatment procedures and CMT.

Dizziness, nausea, or flushing: These symptoms are relatively rare. These are usually temporary and and resolve without any intervention. It is important to notify your Doctor of Chiropractic (D.C.) if you experience these symptoms during or following your care.

Fracture: Rib fractures or other fractures can occur but are extremely rare. It is important to notify your D.C. if you have been diagnosed with or if you are being treated for osteoporosis, if you have previously had a spinal compression fracture, or if you have been previously diagnosed with any "insufficiency" fractures or delayed fracture repair. If you do have any bone weakening disease, your D.C. will modify your treatment or recommend some other type of treatment to minimize your risk of injury or fracture.

Disc herniation or prolapse: Disc bulges or disc herniations are common – even in patients not experiencing the typical symptoms of a "pinched nerve" and may be present at the time of your treatment. It is important to let your D.C. know about any change in sensation, weakness, bowel or bladder control, or if your symptoms change or worsen.

Stroke: A certain type of extremely rare stroke ("vertebral artery dissection" or vertebral artery stroke) is associated with chiropractic care. Recent research indicates the risk of stroke following chiropractic care is virtually the same as the risk of stroke following traditional medical care. With this condition, patients often have neck pain or headache requiring treatment by a healthcare professional. There is no conclusive evidence that CMT is specifically related to the cause of the stroke.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science and I acknowledge that no guarantee or promise of cure can be given as to the results or outcome of my care.

I have read or have had read to me this Informed Consent document. I have discussed or have been given the opportunity to discuss any questions or specific concerns with my D.C. and have had these answered to my satisfaction prior to my signing this Informed Consent document. I have made the decision to accept these risks and continue care voluntarily and on my own free will.

____
Patient's Name (please print legibly)

____________________________________ ____________________
Signature of Patient (or Patient's Legal Guardian) Today's Date

____________________________________ ____________________
Signature of Doctor of Chiropractic (D.C.) Today's Date