

Confidential Patient Information

(Please Print)

Name: _____ SS# _____ Date: _____

Birth Date: ___/___/___ Age: ___ Sex: M ___ F ___ Height: ___ Weight: ___ Marital Status: S M W D

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Cell Phone # _____ Work Phone # _____

Email: _____ Occupation: _____ Employer: _____

Work Address: _____

Spouse Name: _____ SS# _____ Birth Date: _____

Occupation: _____ Employer: _____ Work Phone# _____

of Children _____ Who may we thank for referring you to our office? _____

Current Health Complaints: (in order of importance)

1. _____
2. _____
3. _____

Have you ever had same/similar problems before? Y/N If so, when and for how long? _____

List other Doctors you have consulted for these conditions:

Dr. Name: _____ Address/ Phone: _____

Dr. Name: _____ Address/ Phone: _____

List any medications you are currently taking: _____

Are you currently being treated for any other health conditions that we should be aware of? If so Please explain: _____

Have you ever been to a Chiropractor before? Y/N When? _____

I am interested in a massage therapy evaluation and treatment if necessary. Y/N

If this is an injury sustained from an automobile accident or work related incident, please notify the front desk immediately. Additional forms may need to be completed.

Work related? Y/N Was your employer informed? Y/N

Auto accident? Y/N Date: _____ Name and phone number of attorney: _____

Females: Pregnant? Y/N/Unsure Date of last cycle: _____

Initial consultation is complimentary. However, any additional first visit charges are due when services are rendered.

Method of payment for today's charges: Cash / Check / Charge

Insurance is not required to be a patient in our office. However, if you have insurance that may cover chiropractic care, we would be happy to verify that coverage for you. Please provide your insurance card(s) to the front desk and we will gladly research your insurance benefits.

Signature required on the back side of this form.

AUTHORIZATIONS AND RELEASES FOR OGDEN FAMILY CHIROPRACTIC

Name _____ Date _____

CONSENT FOR TREATMENT

I, _____, the undersigned, a patient in this office, hereby authorize Ogden Family Chiropractic’s physicians and staff to administer treatment as is necessary and certify no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from any insurance company and that the amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my credit. 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. I also understand and agree to pay interest on any unpaid balance that is due at the conclusion/termination of the treatment administered At a rate of 1.5 percent interest per month (18 percent APR) or as allowed by law, until the balance is paid in full.

Patient Signature: _____ Date: _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I authorize and instruct _____ Insurance company / Insurance administrator to pay by check and for it to be made payable to and mailed directly to Ogden Family Chiropractic with the expense benefits allowable and otherwise payable to me under current policy as payment toward the total charges for professional health care services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I hereby agree that this office be given the power of attorney to endorse/ sign my name on any and all drafts for payment of my bills.

If my current policy prohibits direct payment to the doctor, I hereby authorize, instruct and direct you to make out the check to me and mail as follows:

Ogden Family Chiropractic, 7208-4 Market Street, Wilmington, NC 28411

I authorize Dr. Daniel Maggio, DC, or his staff to initiate complaint to the Insurance Commission for any reason on my behalf.

Patient Signature: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I authorize the release of any health care information necessary to process my insurance claim’s and also certify that all insurance information given to Ogden Family Chiropractic is correct and complete.

X-RAY/ HEALTH CARE RECORD RELEASE

I hereby request the release of my x-rays, notes, charts, and all other health care records (my records) which are a part of the records at the offices of _____ (clinic) and request that my records be sent to _____

Patient Signature: _____ Date: _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Ogden Family Chiropractic’s physicians and staff to administer chiropractic care, attention, and treatment as deemed necessary to my son/daughter named _____

Patient Signature: _____ Date: _____

The Chiropractic Office of Ogden Family Chiropractic

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at OGDEN FAMILY CHIROPRACTIC, we may use or disclose personal and health related information about you in the following ways:

- *Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).

Under federal law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:

- *If we are providing health care services to you based on the order of another health care provider.
- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and are unable to obtain your consent after attempting to do so.
- *If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created, or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to: Pat Becker

If you would like further information about our privacy policies and practices please contact: Pat Becker

Patient Authorization for contact regarding chiropractic care, related health services, and/or related health products.

It is our desire for our staff to use you name, address, and/or telephone numbers for the purpose of contacting you to advise you about health related meetings, workshops, and products.

PATIENT HISTORY Name:

Date:

Pt. #:

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

- Y N BROKEN OR FRACTURED BONES Y N OSTEOARTHRITIS Y N EATING DISORDER
Y N CIRCULATORY PROBLEMS Y N EPILEPSY Y N ALCOHOLISM
Y N RHEUMATOID ARTHRITIS Y N PACEMAKER Y N DRUG ADDICTION
Y N SEIZURES/CONVULSIONS Y N STROKES Y N HIV POSITIVE
Y N A CONGENITAL DISEASE Y N CANCER Y N GALL BLADDER
Y N EXCESSIVE BLEEDING Y N ULCERS Y N HEAD/SKULL TRAUMA
Y N HIGH/LOW BLOOD PRESSURE Y N RUPTURES Y N DEPRESSION
Y N DIABETES Y N COUGHING BLOOD Y N TUMORS

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHAT TYPE OF BODY POSTURES DO YOU REPETITIVELY USE OR SUSTAIN DURING YOUR AVERAGE DAY?

- Y N SITTING Y N CRADLING PHONE Y N LOOKING UP
Y N STANDING Y N ARMS OVERHEAD Y N WALKING
Y N INTRICATE WORK WITH HANDS Y N LIFTING Y N HEAD BENT FORWARD
Y N BENDING Y N ARMS EXTENDED FORWARD Y N CLIMBING STAIRS
OTHER _____

HOW OFTEN DO YOU DRINK CAFFEINATED BEVERAGES? _____

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU EXERCISE? YES NO HOW OFTEN? WHAT TYPE? _____

PLEASE LIST AND IDENTIFY WITH A CHECK MARK ALL VITAMINS (V), PRESCRIPTION (Rx), AND NON-PRESCRIPTION (NON-Rx) MEDICATIONS YOU HAVE TAKEN OVER THE PAST YEAR AND/OR ARE CURRENTLY TAKING: (CIRCLE WHO PRESCRIBED, D = DOCTOR, OR S = SELF)

MEDICATION LIST

Table with 7 columns: NAMES OF MEDICATION OR VITAMINS, V, NON-Rx, Rx STRENGTH, DATE STARTED, DATE STOPPED, WHO? D/S. Includes two rows with 'D S' in the WHO? column.

NDRA DRUG ALLERGIES:
