

Starwood Chiropractic

4851 Legacy Drive * Suite 307 * Frisco, Texas 75034 * (972) 377-3909

Patient Information

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Sex: M F Birthdate ___/___/___ Age _____
 Single Married Widowed Separated Divorced
Patient SS # _____
Occupation _____
Employer _____
Employer Address _____
City _____ State _____ Zip _____
Spouse _____
Occupation _____
Whom may we thank for referring you?

Contact Information

Home Phone _____
Work Phone _____ Ext. _____
Other Phone _____
E-mail _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____
Phone _____

Insurance Information

Insured's Name _____
Insured's Birthdate ___/___/___
Relationship to Patient:
 Same Person Spouse Parent Other
Insurance Company _____
I.D./Policy # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above listed insurance company and assign directly to Starwood Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

Responsible Party Signature

Relationship to Patient

Date

Accident Information

If Condition Due to an Accident

Accident Date _____
Type Of Accident: Auto Work Other
To whom have you made a report of your accident?
 Auto Insurance Employer Worker's Comp Other
Attorney Name (if applicable) _____
Attorney Phone _____

Patient Condition

Height _____ Weight _____
Reason for visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse?
 Yes No Unknown

Rate the severity of your pain on a scale from 1 to 10
0-----5-----10

(no pain) (severe pain)

Type of Pain:

- Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramping Stiffness Swelling Other

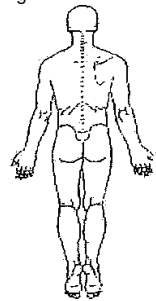
How often do you have this pain (is it constant or does it come and go)? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Additional Comments Concerning Your Condition:

Mark an X on the picture where you continue to have pain, numbness, or tingling



Health History

What treatment have you already received for your condition? Chiropractic Services Medications Surgery
 Physical Therapy None Other _____

Name and telephone number of other doctor(s) who have treated you for your condition _____

Date of Last: Chiropractic Adjustment _____ Medical Appointment _____ Massage _____

Place a mark on "past", "present", or "never" to indicate if you have had any of the following:

<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy Shots <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anorexia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Appendicitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast Lump <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bulimia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pains <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fractures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> General Fatigue	<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gout <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herniated Disc <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lazy Eye <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Function <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mononucleosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful/Frequent Urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia	<p>Past Present Never</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polio <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prosthesis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to Light <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tumors/Growths <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual Disturbance
--	--	--

Females Only

 Birth Control
 Painful Periods
 Hormonal Replacement
 Currently Pregnant
 Trying to Become Pregnant
 Miscarriage

Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):

Medications

Allergies

Vitamins

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

LIFESTYLE

- Smoking
 Alcohol
 Coffee/Caffeine
 Water

Packs/Day _____
Drinks/Day _____
Cups/Day _____
Glasses/Day _____

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Starwood Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below I stat that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name

Patient/Legal Guardian Signature

Date

**STARWOOD CHIROPRACTIC'S HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION**

4851 Legacy Drive, Suite 307
Frisco, TX 75034
972.377.3909

By signing this form, I, _____, authorize the use and use disclosure of my health information as described below:

1. *Description of information:* Disclosure of my condition, prognosis, and treatment plan
2. *Name or class of person(s) or class of persons authorized to make the use or disclosure:* Employees and Authorized Agents of Starwood Chiropractic

3. *Name or identification of person(s) or class of persons authorized to receive the information (please list all family members, spouse name, friends or representatives that we may discuss your medical condition with):*

4. *Date or event when authorization expires:* This authorization does not expire unless:

5. *Description of each purpose of the requested use or disclosure:* Participation in the medical care of the patient or:

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Starwood Chiropractic at the address listed above.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

_____*[Initials of patient or guardian]* I understand that Starwood Chiropractic may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient or Guardian**

Date

Print Name of Patient

Print Name of Guardian

**If an individual's personal representative signs an authorization, the representative's authority is based on:
_____ (e.g., state law, court order, etc.)