

# Henry Chiropractic Clinic Patient Registration and History

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex  male  female Age \_\_\_\_\_ Birth date \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient S.S.# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's name \_\_\_\_\_

Birth date \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Your E-mail: \_\_\_\_\_

## 2

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_

Is patient covered by addition insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Henry Chiropractic Clinic 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 \_\_\_\_\_ Date \_\_\_\_\_

## 3

### PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone \_\_\_\_\_

**In case of emergency, contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ work phone \_\_\_\_\_

## 4

### ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 5

### PATIENT CONDITION

Reason for visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Dates of similar symptoms \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Please mark an "X" on the picture above where you continue to have pain, numbness, or tingling

Rate the severity of your condition on a scale of 1(mild)-10(very severe) \_\_\_\_\_

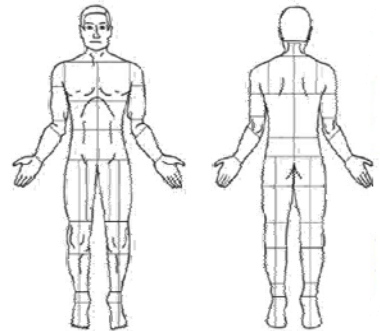
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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



# 6

## HEALTH HISTORY

What treatments have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and contact information for other doctor(s) who have treated your condition \_\_\_\_\_

Date of Last:	Physical Exam _____	Spinal X-ray _____	Blood Test _____
	Spinal Exam _____	Chest X-ray _____	Urine Test _____
	Dental X-ray _____	MRI, CT-Scan, Bone Scan _____	

Place a mark on the "Yes" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes	Emphysema <input type="checkbox"/> Yes	Miscarriage <input type="checkbox"/> Yes	Suicide Attempt <input type="checkbox"/> Yes
Alcoholism <input type="checkbox"/> Yes	Epilepsy <input type="checkbox"/> Yes	Mononucleosis <input type="checkbox"/> Yes	Thyroid Problems <input type="checkbox"/> Yes
Allergy Shots <input type="checkbox"/> Yes	Fractures <input type="checkbox"/> Yes	Multiple Sclerosis <input type="checkbox"/> Yes	Tonsillitis <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Glaucoma <input type="checkbox"/> Yes	Mumps <input type="checkbox"/> Yes	Tuberculosis <input type="checkbox"/> Yes
Anorexia <input type="checkbox"/> Yes	Goiter <input type="checkbox"/> Yes	Osteoporosis <input type="checkbox"/> Yes	Tumors, Growths <input type="checkbox"/> Yes
Appendicitis <input type="checkbox"/> Yes	Gonorrhea <input type="checkbox"/> Yes	Pacemaker <input type="checkbox"/> Yes	Typhoid Fever <input type="checkbox"/> Yes
Arthritis <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Parkinson's Disease <input type="checkbox"/> Yes	Ulcers <input type="checkbox"/> Yes
Asthma <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Pinched Nerve <input type="checkbox"/> Yes	Vaginal Infections <input type="checkbox"/> Yes
Bleeding Disorders <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes	Pneumonia <input type="checkbox"/> Yes	Whooping Cough <input type="checkbox"/> Yes
Breast Lump <input type="checkbox"/> Yes	Hernia <input type="checkbox"/> Yes	Polio <input type="checkbox"/> Yes	Other _____
Bronchitis <input type="checkbox"/> Yes	Herniated Disk <input type="checkbox"/> Yes	Prostate Problem <input type="checkbox"/> Yes	_____
Bulimia <input type="checkbox"/> Yes	Herpes <input type="checkbox"/> Yes	Prosthesis <input type="checkbox"/> Yes	_____
Cancer <input type="checkbox"/> Yes	High Cholesterol <input type="checkbox"/> Yes	Psychiatric Care <input type="checkbox"/> Yes	_____
Cataracts <input type="checkbox"/> Yes	Kidney Disease <input type="checkbox"/> Yes	Rheumatoid Arthritis <input type="checkbox"/> Yes	_____
Chemical Dependency <input type="checkbox"/> Yes	Liver Disease <input type="checkbox"/> Yes	Rheumatic Fever <input type="checkbox"/> Yes	_____
Chicken Pox <input type="checkbox"/> Yes	Measles <input type="checkbox"/> Yes	Scarlet Fever <input type="checkbox"/> Yes	_____
Diabetes <input type="checkbox"/> Yes	Migraine Headaches <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	_____

<b>Exercise</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<b>Work Activity</b> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<b>Habits</b> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____
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Are you pregnant?  Yes  No If Yes, Due Date \_\_\_\_\_

Injury/Surgeries you have had:	Description	Dates
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy name:		
Pharmacy phone:		





# HENRY CHIROPRACTIC

*Helping People Get on the Road to Recovery*

8820 Goodman Road, Olive Branch, MS 38654

Phone: 662-890-5454 or 901-521-7271

## Protecting Your Confidential Health Information is Important to Us

### Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

### *Our Promise!*

The confidentiality of your health records has always been very important to us here at Henry Chiropractic and we have gone to great lengths to help assure the privacy of your health information. New federal laws commonly known as HIPAA (Health Insurance Portability and Accountability Act) have been written to further protect your private health information in today's electronic age. We take these laws very seriously and want you to be able to receive your treatment with confidence that your personal health history will not unnecessarily be made available to others outside our office.

### *So what has changed?*

#### *Why a privacy policy now?*

#### *Very good questions!*

The most significant variable that has motivated the Federal Government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to insure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

*How your*

## HEALTH INFORMATION

*may be used*

### To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies, or other health care personnel providing your treatment.

### To Obtain Payment

We may include your health information with a invoice used to collect payments for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

### In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as, email (unless you tell us that you do not want to receive these reminders).

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

### Public Health and National Security

We may be required to disclose to Federal Officials or military authorities' health information necessary to complete an investigation related public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

### For Law Enforcement

As permitted or required by State or Federal law, we may disclose you health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the care of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

### To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

### Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

### Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

### Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

### Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

### Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

### Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the changes.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

### Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

### Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Signature

Date