DATE_____ FIRST NAME_____MI_____LAST NAME_____

SEX____ HEIGHT_____ WEIGHT_____ AGE_____ BIRTHDATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE # CELL _____ HOME _____WORK _____EMAIL_____

CONTACT PREFERENCE: CELL PHONE_____ HOME_____ WORK_____ SOCIAL SECURITY#_____

EMPLOYER_____ADDRESS_____

OCCUPATION_____HOW LONG?_____

MARITAL STATUS_____ NAME OF SPOUSE_____

SPOUSES EMPLOYER_____EMPLOYERS ADDRESS_____

HOW DID YOU HEAR ABOUT OUR CLINIC?_____

LIST YOUR COMPLAINT(S) GRADE EACH COMPLAINT: MILD(1) MODERATE(2) SEVERE(3) DATE YOUR PAIN STARTED

1)_____

2)_____

3)_____

COMPREHENSIVE DESCRIPTION OF CAUSE (accident, injury, etc.) AND DATE

_____

_____

WHAT POSITIONS OR MOVEMENTS AGGRAVATE YOUR COMPLAINTS?

_____

_____

HOME HEALTH CARE AND EFFECT

_____

_____

LIST DOCTORS CONSULTED FOR THIS CONDITION:

NAME_____ADDRESS_____

SPECIALTY_____DATES_____RESULT: GOOD____ FAIR_____ POOR_____

DIAGNOSIS AND TREATMENT_____

_____

NAME_____ADDRESS_____

SPECIALTY_____DATES_____RESULT: GOOD____ FAIR_____ POOR_____

DIAGNOSIS AND TREATMENT_____

DATE_____FIRST NAME_____MI____LAST NAME_____

Are you seeing any other providers for other problems or health conditions? YES or NO (please circle)

Please list the problems(s), date problem(s) began and Provider(s) treating you for the conditions.

_____
_____
_____

Past history—

Have you--- If YES, Please list the date and the name of the treating provider.

ever been diagnosed with hypertension? Yes or No_____

been hospitalized in the last 5 years? Yes or No_____

been diagnosed with Diabetes? Yes or No _____Type I_____ Type 2____

Do you smoke?___ Never___ Former smoker___ Current/Every day smoker___ Current/ Some day(s)smoker_____

Vitals (For office use only) Height_____ Weight_____ Blood Pressure_____

Medications

What medications are you currently taking? Please include all non-prescription and over the counter vitamins, herbs, minerals, etc. List date started, brand name, strength, dosage, frequency, duration, quantity, refills available, prescribed by. Please be as specific as possible.

_____
_____
_____
_____
_____

Do you have any allergies?_____ Food_____ Environmental_____ Medication_____

List type of allergy and reaction(s)

_____
_____
_____
_____

Thank You for Your Cooperation

A copy of your insurance card(s) will be made, in addition, please complete the information requested below.

Are you the policy holder? YES or NO If No, who is? Spouse_____ Parent____ Employer___ Other_____

Policy Holder's First Name _____ Last Name_____DOB_____

Policy Holder's Employer_____

Do you have secondary insurance? YES or NO If Yes, please complete the following:

Policy Holder's First Name _____ Last Name_____DOB_____

Policy Holder's Employer_____

Information about Advanced Health PA Privacy and Financial Policies

I authorize release of necessary medical records and benefit payment to the clinic. The clinic will aid in processing of insurance claim forms. This account remains my responsibility, including 2% interest per month added to overdue accounts - $2.00 minimum. Patient will be responsible for collection agency fees up to 35% of the outstanding balance as well as any court costs and legal fees necessary to collect debt. I understand I have only received an estimate of charges. Further, I understand that missed appointments not canceled at least 24 hours in advance will result in a fee of $50.

Our Privacy Policy

The Practice:

- **A) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI**
- **B) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.**
- **C) Is required to abide by the terms of this Privacy Notice.**
- **D) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.**
- **E) Will distribute any revised Privacy Notice to you prior to implementation.**
- **F) Will not retaliate against you for filing a complaint.**

Informed consent

I have been explained my condition or what is known about it presently.
I have been explained the benefits and risk of chiropractic adjustments.
I have been informed of my treatment options.

Patient Acknowledgement

Authorization for Minors (under 18 years of age)

I _____authorize the examination and treatment of_____

at Advanced Health PA. Signed (Guarantor)_____ Date_____

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms. Patient_____ Date_____