EVANS FAMILY CHIROPRACTIC

PATIENT INFORMATION	INSURANCE			
Date	Who is responsible for this account? Relationship to Patient Insurance Co & Group # Is patient covered by additional insurance? Yes No Subscriber's Name Birthdate SS# Relationship to Patient Insurance Co & Group # ASSIGNMENT AND RELEASE I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to and assign directly to 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			
PHONE NUMBERS HomeWorkExt	A CCIDE NT INFORMATION Is condition due to an accident? Yes No Date			
Best time and place to call	Type of accident: Auto Work Home Other			
IN CASE OF EMERGENCY CONTACT:	To whom was accident reported? Auto Insurance Employer Worker's Comp Other			
Name Relationship Home Work	Attorney Name (if applicable)			
PATIENT	CONDITION			
Reason for Visit When did your symptoms appear? Is this condition getting progressively worse? Yes Rate the severity of your pain on a scale from 1 (least p Type of Pain: Sharp Dull Throbs Numb Act Tingles Cramps Stiffness Swell How often do you have this pain?	Mark picture with an X where symptoms occur s No Unknown pain) to 10 (severe pain) thes Shooting Burns ling Other			

HEALTH HISTORY

Physical Exam Spinal X-Ray Urine T est Spinal Exam	Have you ever re	ecieved chird	opractic care in the pas	t? Yes No	When?	Res	sults?	
Spinal Exam Chest X-Ray Urine T est Dental X-Ray MRI, CT-Scan, Bone Scan Comparison Compar	Date of last:							
Dental X-Ray	Physic	al Exam		Spinal	X-Ray		Blood Test	
ircle P = Previously C = Currently IDS/HIV P C Emphysema P C Miscarriage P C Scarlet Fever P C IDS/HIV P C Epilepsy P C Mononucleosis P C Stroke Ilergy Shots P C Epilepsy P C Mononucleosis P C Stroke Ilergy Shots P C Epilepsy P C Mononucleosis P C Stroke Ilergy Shots P C Fractures P C Multiple Inorexia P C Glaucoma P C Sclerosis P C Thyroid Inorexia P C Golter P C Mumps P C Thyroid Inorexia P C Golter P C Mumps P C Thyroid Inorexia P C Golter P C Mumps P C Thyroid Inorexia P C Golter P C Mumps P C Thyroid Inorexia P C Golter P C Mumps P C Thyroid P C Thyroid Inorexia P C Golter P C Thyroid P C Thyroid P C Thyrid P C Thyrid P C Thyroid P C Pacemaker P C Thyroid P C Pacemaker P C Thyroid P C Pacemaker P C Thyroid P C P P C Thyroid P C P P C Thyroid P C P C P P C P P C P P C P P C P P C P P C P P P C P P P C P P P C P P P C P P P P C P	Spinal	Exam		Chest)	K-Ray		Urine T est	
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EVANS FAMILY CHIROPRACTIC

HIPPA Release
I understand that some of my health information may be used and/or disclosed to the doctor of Evans Family Chiropractic to carry out treatment, payment, or health care operations, and that a complete description of such uses and disclosures has been made available to me in writing. I also understand that I can request a copy of this privacy notice entitled "Our Privacy Policies", and that disclosures of my health information for any other reason must be agreed upon by me in writing. Initial:
Health Insurance/Payment Information
I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Erik R. Evans and this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Initial:
Informed Consent to Chiropractic Treatment
The Nature of Chiropractic Treatment: Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. Chiropractors commonly use their hands or a mechanical device or the use of tables in order to restore mobility and function of joints that are not moving or functioning optimally. For many patients certain therapies or exercises may also be used to maximize healing and pain relief.
Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen or having braces put on your teeth). Other rare but potential complications include muscular strain, fractures of bone, injury to interverteberal discs, nerves or spinal cord, or stroke/cerebrovascular injury (estimated to be less that 1 in 2 million to 5.8 million cervical manipulations). Complications from therapies used in addition to your adjustment are rare but may cause skin irritation, burns, soreness, bruising, or other minor complications.
Risks of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or surgery.
I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. Initial:
Patient Printed Name:
Patient Signature: