Vida Chiropractic Center

NEW PATIENT APPLICATION

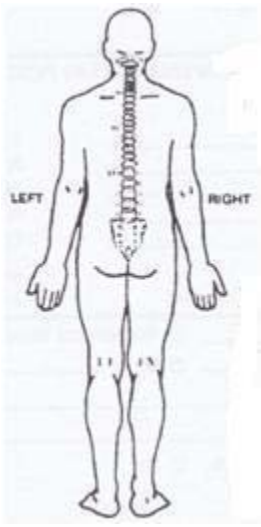
Welcome! We thank you for choosing our practice for your chiropractic needs. Please thoroughly complete all questions. Thank You.

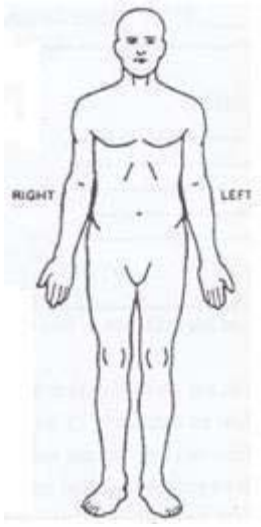
PATIENT INFORMATION

Name _____ Preferred Name: _____Date_____/____/_____
Address _____ City _____ State _____ Zip _____
Phone: Home (_____) _____- _____ Cell (_____) _____-_____ Work (_____) _____-_____
Email _____ SS#_____-____-_____ Driver license _____Birth Date ___/____/_____
Age _____ Sex: Male☐ Female☐ Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Minor☐ Widowed☐
Occupation_____ Employer_____
Business Address _____ City _____ State _____ Zip _____
Spouse's or Parent's Name _____ Employer _____ Work # (_____) _____-_____
Children's names and ages_____
Person to contact in case of emergency_____ Phone (_____) _____-_____
Whom may we thank for referring you to our office? _____ _____
Hobbies_____

CURRENT HEALTH CONDITION

Reason for seeking chiropractic care_____
Is this condition: getting worse☐ intermittent☐ constant☐ Is your complaint worse during: morning☐ evening☐ constant☐
How long have you had the above complaint? _____How often do you have the above complaint?_____
Does this condition interferes with: Work☐ Sleep☐ Exercise☐ Hobbies☐ Other☐_____
Does your condition worsens when: Bending☐ Sitting☐ Standing☐ Walking☐ Lying Down☐ Weather☐ Other☐_____
Do you feel?: Pain☐ Numbness☐ Tingling☐ Aches☐ Cramps☐ Swelling☐ Burning☐ Stiffness☐ Other☐_____
In a scale of 1-10 (1 least, 10 most), please rate the severity of your symptoms: 1 2 3 4 5 6 7 8 9 10
Is your pain?: Sharp☐ Dull☐ Throbbing☐ Constant☐ Intermittent☐
What treatment have you already received for your condition: Medication☐ Surgery☐ Physical Therapy☐ Other☐_____
Name and address of other doctor(s) who have treated you for this condition:_____
Where is the problem? Please, place an "x" in the illustrations below to show where you feel pain, numbness, tingling or other problems:





CHIROPRACTIC HISTORY

Have you ever had chiropractic care before: Yes☐ No☐ If yes, please tell us the doctor's name_____
Reason for care_____ Did you follow doctor's recommendations for care_____
Are other family members under chiropractic care? Yes☐ No☐ Who?_____
Was your previous chiropractic experience?: positive☐ negative☐ neutral☐

Please, continue in the back ►

HEALTH HISTORY

Do you consume: coffee□ tea□ alcohol□ artificial sweeteners□ recreational drugs□ sugar□ caffeinated beverages□
Are you taking: Pain killers/Muscle relaxants□ Blood pressure pills□ Sleep aids□ Insulin□ Other□ Please, list_____
Please, list any vitamins/herbs/homeopathic/other you take _____
Are you under care of other health professionals? No□ Yes□ If yes, please name them and their specialty_____
_____
Do you exercise? No□ Yes□ What kind?_____ Frequency: 2-3x/week□ 4-6x/week
What do you daily work habits include? Sitting□ Walking□ Standing□ Bending□
Do you smoke: Yes□ No□ How long have you smoked?_____ How many cigarettes a day? _____
In what position do you sleep? Face up□ On the side□ On my stomach□
If female, are you pregnant? Yes□ No□ Are you nursing? Yes□ No□ Do you take birth control pills? Yes□ No□

Past injuries can affect present health. Let us know if you had some of the following (please, check all that apply):

□ falls/accidents	□ head injuries	□ plastic surgery
□ sport injuries	□ broken bones	□ dislocations
□ spinal tap	□ surgery	□ extensive dental work

Do you have, or have you had, any of the following (please, check all that apply):

□ difficulty sleeping	□ slipped disc	□ menstrual cramps	□ osteoporosis	□ liver disease
□ arthritis	□ pinched nerve	□ irregular periods	□ thyroid disease	□ kidney disease
□ seizures	□ cancer	□ infertility	□ whooping cough	□ anemia
□ eczema	□ dizziness	□ depression	□ heart disease	□ diabetes
□ neck pain	□ heart problems	□ allergies	□ excessive thirst	□ asthma
□ mid back pain	□ high blood pressure	□ stuffy nose	□ frequent nausea	□ heartburn
□ low back pain	□ ankle swelling	□ weight loss	□ vomiting	□ gas/bloating
□ headaches	□ cold extremities	□ poor appetite	□ prostate problems	□ colitis
□ migraines	□ blurred vision	□ excessive appetite	□ bladder trouble	□ irritable bowel
□ hand pain/tingling	□ vision problems	□ nervousness	□ breast pain/lumps	□ constipation
□ feet pain/tingling	□ difficulty breathing	□ confusion	□ leg cramps	□ bloody stools
□ chest pain	□ fatigue	□ dental problems	□ painful urination	□ hemorrhoids

HEALTH GOALS

At Vida Chiropractic Center, we are dedicated toward providing quality chiropractic care and lifestyle coaching to our members, with the intent of educating and empowering them so they can achieve optimal health and well being. Beyond our goals, we want to learn and understand about your own health goals. Please, tell us what you would like to gain from chiropractic care:
Temporary/symptom relief□ Health restoration□ Health optimization□ Wellness & Prevention□ Improved Performance□

FINANCIAL RESPONSABILITY

Name of person responsible for this account (if different from patient) _____
Relationship to patient _____ Birth Date__/___/____ SS#_____-____-_____ Home Phone(_____) _____-_____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work Phone # (_____) _____-_____

INSURANCE INFORMATION

Insurance Co. Name _____ Insurance ID#_____
Name of Insured (if different from patient) _____ Relationship to patient _____
Insured's date of birth _____/____/____ Insured's Social Security # _____-_____-_____
Insured's employer_____ Work phone (_____) _____-_____
Employer address _____ City _____ State ____ Zip _____
Additional Insurance_____ Insurance ID #_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services non-covered that had been rendered on my behalf or my dependents. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me or my dependents will be immediately due and payable.

X_____ _____/_____/_____
SIGNATURE OF PATIENT (or parent if minor) DATE

Vida Chiropractic Center

Terms of Acceptance – Informed Consent for Care

When patients seek chiropractic care and when we accept patients for such care, it is essential that we are all working towards the same goal to prevent confusion or misunderstandings. It is, therefore, important that the patient understands the goal and the means used to attain it.

The **goal of chiropractic** is to find vertebral misalignments that interfere with the nervous system's proper function (**vertebral subluxations**), and to remove that interference so that the body can heal naturally.

These interferences to the nervous system are removed by means of **chiropractic adjustments**, an application of specific and well directed forces over the spine, by hand or instrument, with the goal of restoring normal nerve function, improving brain-body connection and optimizing health.

The results of chiropractic care in most people are phenomenal. However, the time necessary to get those results may vary. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. In most people, health returns quickly. In some, there is a more gradual response. The speed of your return to health or performance improvement is dependent upon your physical condition and dedication to your health.

Chiropractic care, like all forms of health care, while offering considerable benefits, may also provide some level of risks. These risks are most often minimal, yet in rare cases, injury has been associated with chiropractic care. Some complications reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, fractures and, the rarest, vertebral artery injuries that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed to assess your specific condition, your overall health and, in particular, your spine/nervous system health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are required. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

This office does not engage in the medical practice of diagnosis or treatment of disease. Regardless of what the disease is called, we do not offer to treat it. Our only **practice objective** is to remove nerve interference so the body can heal itself naturally. Our only **methods** are specific adjustments to correct vertebral subluxations. However, we may use other procedures to help your body maintain proper alignment and brain-body communication.

I _____ (Please, print) have read the above, understand it fully, and undertake chiropractic care on this basis.

Signature: _____ Date: _____ / _____ /_____

Vida
Chiropractic Center

PRIVACY NOTICE - AUTHORIZATION FORM

The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur during your care, payment of your bills, or in the performance of this chiropractic office's operations. Please, review it carefully.

SPECIFIC AUTHORIZATIONS. I hereby give permission to Vida Chiropractic Center **(VCC)** to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to VCC to use my address, phone and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters and others.
- I give permission to VCC to contact me by phone, to leave a message on my answering machine or voicemail.
- I give permission to VCC to use my name and photograph on the patient welcome board, picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to VCC to use any testimonial written by me for marketing purposes.
- I give VCC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for the conversation to take place in a private setting.
- I give VCC permission to disclose my health and billing records to third party payers who are responsible for payments of services rendered to me.
- I give VCC permission to disclose my PHI to another health care provider if necessary for further diagnosis, assessment or treatment.

RIGHT TO REVOKE AUTHORIZATION. You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of **VCC**. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this authorization;
- The date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official.

-You have the right to refuse to sign this authorization. If you refuse to sign this, **VCC** will not refuse to provide care. However, it will not be possible for **VCC** to file third party billing on your behalf and you will be responsible for: 1) payment in full at the time services are rendered to you, 2) scheduling your own appointments since **VCC** will be unable to contact you, 3) all contact with **VCC** regarding your care.

-You have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to you. This authorization will remain in effect for the duration of your care at VCC plus 7 years or until revoked by you.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of the Notice of Privacy Practices for Protected Health Information.

Patient's name: _____ Patient's Signature:_____
Social Security #: _____ DOB:_____/_____/_____ Today's Date: _____/_____/_____
Parent or Representative Name (if minor):_____Signature:_____
Signature of Privacy Official:_____