HOMETOWN CHIROPRACTIC
1549 Ft Harrison Rd, Terre Haute, IN 47804
Phone (812)460-4700 FAX (812) 460-4701

# Confidential Patient Information

Date | Age | DOB ((Mo/Day/Year) | Sex | Marital Status

First & Last Names | Social Sec #

Street Address | City | State | Zip Code

Mobile Phone ( ) | Home Phone ( ) | Work Phone ( )

Home e-mail _____Work e-mail _____

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

☐ **I do not want** appointment reminders via text message.

Occupation | Employer | Location

Race (check one)

☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native
☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian or other Pacific Island
☐ Samoan ☐ Guamanian or Chamorro ☐ Other_____ ☐ I choose not to specify

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐I choose not to specify

Preferred Language (check one)

☐ English ☐ Spanish ☐ American Sign Language ☐ Chinese ☐ French ☐ German
☐ Tagalog ☐ Vietnamese ☐ Italian ☐ Korean ☐ Russian ☐ Polish
☐ Arabic ☐ Portuguese ☐ Japanese ☐ French Creole ☐ Greek ☐ Hindi
☐ Persian ☐ Urdu ☐ Gujarati ☐ Armenian ☐ I choose not to specify

Guardian/Spouse's Full Name | D.O.B. | Social Sec #

Name, work phone and city of nearest relative (not your spouse):

Were you referred to a certain doctor in this office? Is your visit due to an accident? □ No □ Yes

Verification Question (choose only one question by circling the question, then give the answer to that question)

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?

☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?

☐ What was the make of your first car? ☐ When is your anniversary?

Verification Answer to the Chosen question: _____

*Answers must be at least 6 characters*

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Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest Very Interested

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Have you had an X-ray or CT scan or MRI of your low back or neck spine in the past 2 years? ☐ Yes ☐ No

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**Family Medical History**

Do you have any direct relatives (mom, dad, brother, sister, children, grandparents) been diagnosed with cancer (need specific site), diabetes (I / II), heart disease, or stroke?

Illness: _____ Illness: _____

Relation: _____ Relation: _____

Age of onset: _____ Age of onset: _____

Die from illness: ☐ Yes ☐ No Die from illness: ☐ Yes ☐ No

Illness: _____ Illness: _____

Relation: _____ Relation: _____

Age of onset: _____ Age of onset: _____

Die from illness: ☐ Yes ☐ No Die from illness: ☐ Yes ☐ No

**YOUR PRESENT COMPLAINT(S)**

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List other doctor(s) seen for this condition:

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Personal Medical history (if any of the following are relevant to your medical history, please check the accompanying box:)

| | | | |
|---|---|---|---|
| □ Cancer | □ Muscular Dystrophy | □ Rheumatic Fever | □ Digestive Disorders |
| □ Polio | □ Multiple Sclerosis | □ Scarlet Fever | □ Sinus Trouble |
| □ Tuberculosis | □ Convulsions | □ Nervousness | □ Backaches |
| □ Arthritis | □ Epilepsy | □ Asthma | □ Numbness |
| □ Heart Trouble | □ Concussion | □ Dizziness | □ High Blood Pressure |
| □ Diabetes | □ Hepatitis | □ German Measles | □ Venereal Disease |

Describe any operations you've had and the dates:

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Have you been treated by a physician for any health condition in the last year? □ Yes □ No

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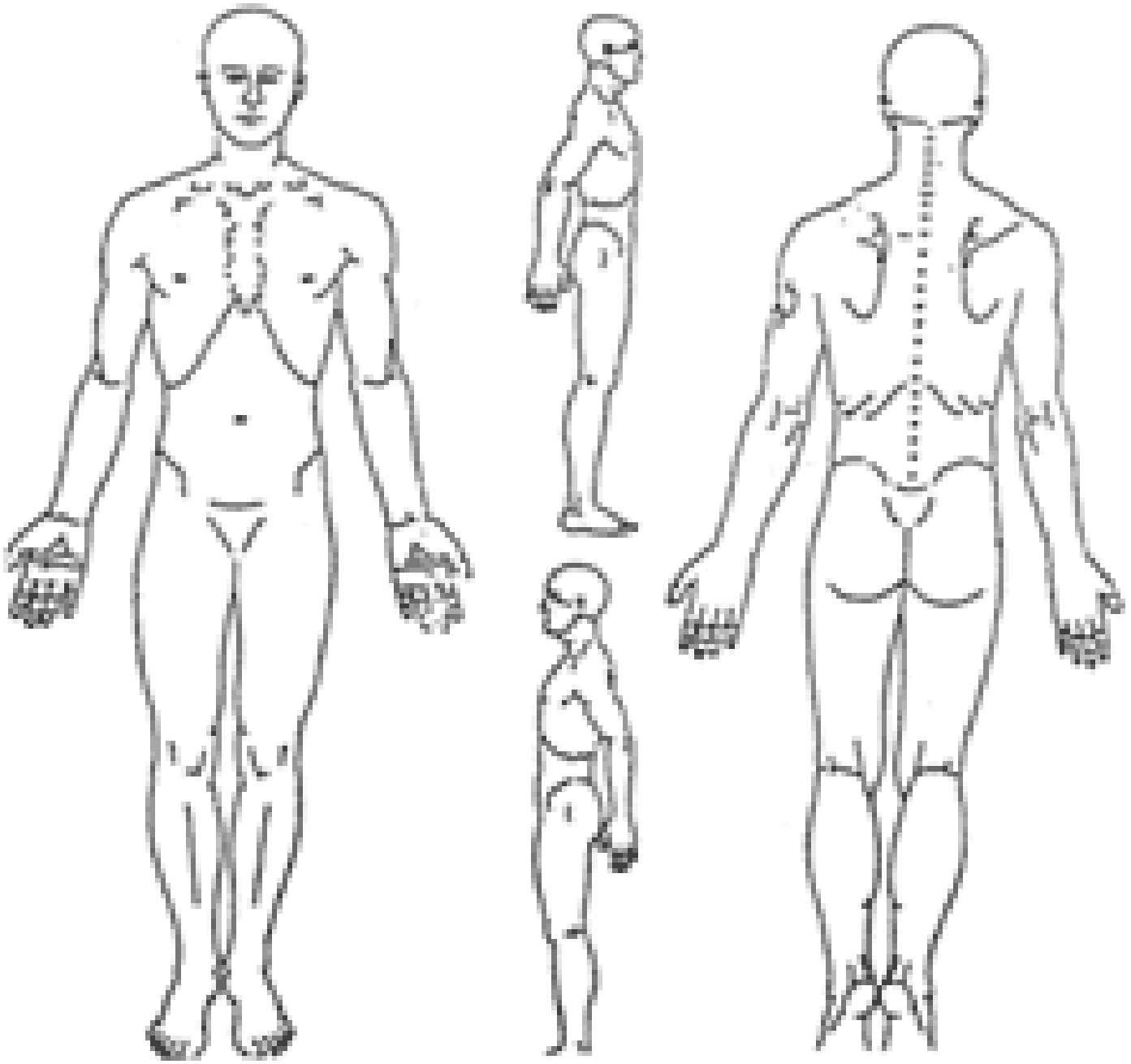
**Pain Diagram**

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x x | Ø Ø Ø Ø Ø |



Describe Condition

Date of last physical exam

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Are you now taking any medication? □ Yes □ No. What kind?

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Are you allergic to any medication? □ Yes □ No. What kind?

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Are you pregnant? □ Yes □ No. Date of last menstrual period:

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I understand and agree that health and accident insurance 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Hometown Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I agree, in order for Hometown Chiropractic to service my account or to collect any amounts I may owe, Hometown Chiropractic may contact me by telephone or any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Hometown Chiropractic may also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Hometown Chiropractic may contact me as described above. If you fail to meet the financial obligations to this office, you agree to be responsible for collection fees of 40%, attorney's fees and court cost I hereby authorize the doctors of Hometown Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

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**Patient's (Parent or Guardian's) Signature** **Date**

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## *ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

Patient Name: _____

Address:_____

I have been given a copy of Hometown Chiropractic's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Hometown Chiropractic has the right to change this *Notice* at any time. I may obtain a current copy by contacting Hometown Chiropractic's Privacy Official, or by visiting the Hometown Chiropractic web site at _www.myhometownchiropractic.com__.

**My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:***

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)