HURNE CHIROPRACTIC

Today's Date: ________________

Patient Information

Title: _____ First Name: ________________________ Last Name: ________________________

Date of Birth: ____________________________ Sex: ☐ Male ☐ Female

Address: ____

City: ___________________________________ State: ______________ Zip: ______________

Primary Phone: _________________________ Secondary Phone: _______________________

Email Address: ____

How did you hear about us? Were you referred? By whom?

____

Emergency Contact Information

Name of Contact: ______________________________ Relationship: ______________________

Address: ____

City: ___________________________________ State: ______________ Zip: ______________

Phone: _________________________________ Email: _________________________________

Primary Care Provider

Name: _________________________________ Phone: _________________________________

Address: ____

City: ___________________________________ State: ______________ Zip: ______________

Smoking Status

Are you a current smoker? ☐ Never ☐ Yes ☐ No, I've quit!

If yes, how many packs per day and how long have you been smoking?

____

If no, how long ago did you quit? ____

Allergies

Please list any allergies to medications or otherwise, that you currently have or have experienced in the past.

____

____

____

Patient’s Name: ___________________________________ Date of Birth: ________________

Medications

Please list any medications, including over-the-counter, you are currently taking and dose.

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Supplements

Please list all natural products (vitamins, herbal medications) you are currently taking and dose.

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____

Current Complaint

Please describe your current condition or concern – things to include: type of concern, location, when it began, any changes since it began.

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____

Please list any other health concerns:

____

____

Medical History

Please list any medical conditions or diagnoses you currently have or have received in the past:

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____

Please check if you have had any of these following conditions:

☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ An Inflammatory Arthritis

Please list any surgeries, procedures, or hospitalizations you have had with their dates.

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____

Patient's Name: ____________________________ Date of Birth: _____________

Medical History, Continued

Please list any motor vehicle accidents or injuries.

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____

Family History

Please list any family medical history.

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____

____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐ I prefer not to say

Number of Children: ________________

What do you do for a living? What have you done for the longest?

____

Wellness History

Do you consume alcohol? If so, what type and how many drinks per week?

____

How many cups of caffeinated coffee or tea do you drink in a day? ________________

How many glasses of soda / pop do you drink in a day? ________________

How many glasses of water do you drink per day? ________________

Do you use recreational drugs? If so, what type(s) and how often?

____

How healthy do you feel your diet is? ☐ 1: Poor ☐ 2 ☐ 3 ☐ 4 ☐ 5: Excellent

How stressed do you feel daily? ☐ 1: Not stressed ☐ 2 ☐ 3 ☐ 4 ☐ 5: Very Stressed

Have you ever accessed or felt the need to access care for mental health? ☐ Yes ☐ No

How many hours of sleep do you get per night? ________________

What do you like to do for exercise and how often do you exercise?

____

Please list any health goals you have:

____

Patient's Name: ___________________________________ Date of Birth: ________________

Consent for Chiropractic Treatment and Procedures

I understand that:

- During my visit, my doctor may recommend that a procedure be performed. Such procedures include but are not limited to: chiropractic adjustment, soft tissue manipulation, stretches and exercises.
- The risks, benefits, and alternatives to these procedures will be explained at the time of my visit, prior to my doctor performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Procedures are optional. I may choose to decline a procedure for any reason.
- There is no guarantee of results as healthcare is not an exact science.
- Some procedures may need to be performed more than once to achieve optimum results.
- Procedures may incur additional charges, and I am responsible for payment.
- I may receive a receipt for my treatment to send to my insurance company.

I have read the above, and I consent to routine minor procedures and chiropractic treatment.

Signature: ____

Patient Permission Statements

Please check each box indicating your agreement then please sign the following statement.

☐ Privacy Verification: I know I may request a copy of the Privacy Policy and understand it describes how my personal health information (PHI) is protected and released on my behalf only as needed for treatment or coordination of services.
☐ Permission to Contact: I grant permission to be called to confirm or reschedule my appointment and have voicemail left for me and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.
☐ Payment Verification: I acknowledge that I am responsible for the payment of any services I receive.
☐ General Verification: To the best of my ability, the information I have supplied today is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

I understand the above listed check boxes (Privacy Verification, Permission to Contact, Payment Verification, and General Verification) and my signature indicates my agreement.

Signature: ____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor ☐ Personal representative of person with disabilities

Name: ________________________________ Relationship: ___________________________

Phone: ________________________________ Email: _________________________________

HURNE CHIROPRACTIC

Office Policies & Procedures

- Hurne Chiropractic DOES NOT participate in ANY insurance programs. Depending on your plan, your insurance company may reimburse you.
- Hurne Chiropractic DOES NOT participate in Workers Compensation.
- Hurne Chiropractic DOES NOT participate in Medicare.
- Hurne Chiropractic DOES NOT accept assignment (direct payment) from no fault. In these cases payment is expected up front. We will provide receipts OR a statement for you to submit and are more than happy to fill out any paperwork required.
- Payment is due at time of service rendered
- Payment is accepted in the form of cash, check, or credit card.
- If payment is not collected at the time of service, there will be a billing fee.
- If you believe you have received a bill in error, please contact our office immediately.
- If any documentation or forms are needed, please allow up to 7 days to fill the request.
- At Hurne Chiropractic, we are required to adhere to HIPAA laws. Therefore, if you desire any other person(s) to have access to your information, please speak to the receptionist to make sure you have all the proper paperwork filled out.
- If you need to cancel an appointment, please give as much notice as possible.
- If you are running late for an appointment, please call to inform us.
- A signed copy of this form will be kept electronically as part of your record.

I acknowledge that I have read and received a copy of Hurne Chiropractic's Office Policies and Procedures.

______________________________ ____________________

Signature **Date**

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