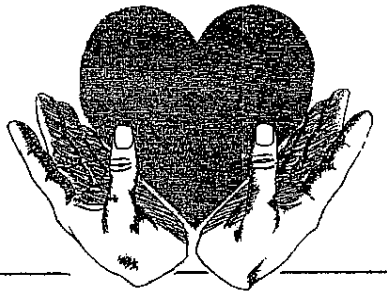

Gentle Chiropractic Care Center

DR. GERALD E. DICKSON
8547 East Marekt Street
Warren, Ohio 44484

PERSONAL HISTORY

NAME _____ HOME PHONE _____ WORK PHONE _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____ SS# _____

DATE OF BIRTH _____ AGE ___ M _ F _ MARITAL STATUS: S __ M __ W__ D __ Student: Full time ___ Part time _____

EMPLOYER'S NAME / ADDRESS _____ OCCUPATION _____ YEARS ___

Do you have health and accident insurance? ____ If yes, with what company? _____ Policy # _____

Are you a member of an H.M.O.? _____ Additional insurance self/spouse, Policy # _____

If retired, state company name that you retired from, which your group health insurance is with _____

INSURED's NAME _____ EMPLOYER'S NAME AND ADDRESS _____

DATE OF BIRTH _____ SS# _____ OCCUPATION _____ WORK PHONE _____

Are you covered under spouse/parent's insurance? _____ If yes, with what companies? _____ Policy # _____

How did you find out about us? ( ) Newspaper ( ) Flyer ( ) Yellow Pages ( ) Radio ( ) Friend ( ) TV_____( ) Other

Person to call in an emergency _____ Phone _____ Relationship _____

Have you ever been a patient here before? _____ When? _____ For what problems? _____

PRESENT COMPLAINT IS DUE TO: CHECK (1) OR MORE OF THE FOLLOWING

☐ ON THE JOB INJURY (USE FORM)	☐ AUTO ACCIDENT (USE FORM)	☐ ILLNESS
☐ HOME INJURY (USE FORM)	☐ ACCIDENT NOT IN HOME	☐ DISEASE
☐ ATHLETIC INJURY	☐ SOMEONE ELSES NEGLIGENCE	☐ OLD INJURY
☐ SCHOOL SUPERVISED SPORT	☐ POOR PHYSICAL CONDITION	☐ OTHER (EXPLAIN)

CURRENT PROBLEM

What is the main health problem you want to talk to the doctor about? _____

Date first noticed pain: _____ How long have you had this condition? _____

When was the last time? _____ What activities aggravate your condition? _____

Is the condition getting worse? ( ) Yes ( ) No ( ) Comes and Goes Number of episodes per day ___ week___ month___

Condition interfering with your ( ) Work ( ) Sleep ( ) Daily routine ( ) Other _____

I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all services rendered. I agree that if my treatment here is suspended or terminated, bills become immediately due and payable. All x-rays are the property of Gentle Chiropractic Care Center . I authorize Gentle Chiropractic Care Center to file a written formal complaint to the insurance commissioner, or Department of Labor on my behalf.

DATE:_____

_____
SIGNATURE OF PATIENT OR GUARDIAN

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Appendicitis
Scarlet Fever
Diphtheria
Typhoid Fever
Pneumonia
Rheumatic Fever
Polio
Malaria
Tuberculosis
Whooping Cough
Anemia
Measles
Mumps
Small Pox
Chicken Pox
Diabetes
Cancer
Heart Disease
Goiter
Influenza
Pleurisy
Alcoholism
Venereal Infection
Arthritis
Epilepsy
Mental Disorder
Lumbago
Eczema

Please Circle All Of The Following Symptoms You Have Now.

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or pain in arms, hands, or legs
Allergy
Wheezing
Neuralgia

E.E.N.T.

Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay fever

SKIN

Skin Eruptions
Itching
Bruises easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

CARDIO-VASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

MUSCLE & JOINT SYMP.

Stiff neck
Backache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
Faulty posture

GENITOURINARY SYMPTOMS

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney Infection or Stones
Bed Wetting
Inability To Control Urine
Prostate Trouble

GASTROINTESTINAL SYMPTOMS

Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Are you pregnant?
☐ Yes ☐ No

Gentle Chiropractic
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Gentle Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Gentle Chiropractic

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ [Name of Individual], authorize Gentle Chiropractic to release my Protected Health Information, as described below, to:

RECIPIENT(S) INFORMATION:

Name of Health Care Provider/Plan/Other Insurance Co

Street Address

City, State, Zip Code

Name of Health Care Provider/Plan/Other Primary Care Phy.

Street Address

City, State, Zip Code

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

- ✓ Complete Medical Record
- ✓ Medical History, Evaluation Records
- ___ Immunizations
- ✓ Treatment or Tests
- ✓ Hospital Records Including Reports
- ✓ X-ray Reports
- ✓ Allergy Records
- ✓ Laboratory Reports
- ✓ Prescription Data
- ✓ Consultation Documentation
- ✓ Surgical Reports
- ___ Other (Specify):

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): ✓ HIV/AIDS, ✓ Substance Abuse (alcoholism or drug abuse), or ✓ Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

- ✓ At the request of the individual (no purpose need be specified)
- ✓ Additional Medical Care
- ✓ Insurance Eligiblity/Benefits
- ✓ Change of Provider
- ✓ Legal Investigation or Action
- ___ Other (Specify):

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Alison Dickson at (330) 8566999. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this

Authorization.

EXPIRATION DATE: This Authorization is valid until _____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE:

REPRESENTATIVE'S SIGNATURE (IF APPLICABLE):

_____

_____

REPRESENTATIVE'S

DESCRIPTION OF RELATIONSHIP:

DATE: _____

_____

DR. GERALD E. DICKSON

GENTLE CHIROPRACTIC CARE CENTER
DR. GERALD E. DICKSON
8547 EAST MARKET STREET
WARREN, OHIO 44484
(330) 856-6999

1)I,_____, AUTHORIZE THE PERFORMANCE UPON MYSELF OF THE FOLLOWING PROCEDURES:
EXAM, X-RAYS, REPORT OF FINDINGS, MANIPULATION, ANCILLARY THERAPIES TO BE PERFORMED BY OR UNDER THE DIRECTION OF DR. GERALD E. DICKSON.

2)I ALSO CONSENT TO THE PERFORMANCE OF OTHER DIAGNOSTIC AND THERAPEUTIC PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE STATED ABOVE, WHETHER OR NOT ARISING FROM PRESENTLY UNSEEN CONDITIONS, THAT THE ABOVE-NAMED DOCTOR, ASSOCIATES OR ASSISTANTS, MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF MY HEALTH CARE.

3)THE NATURE AND PURPOSE OF THE PROCEDURES, POSSIBLE ALTERNATIVES, THE RISK INVOLVED, THE POSSIBLE CONSEQUENCES AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN EXPLAINED TO ME BY THE ABOVE NAMED DOCTOR AND OR HIS ASSOCIATES AND ASSISTANTS.

4)I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE AS TO THE RESULTS THAT MAY BE OBTAINED FROM THE PROCEDURE HAS BEEN GIVEN BY THE ABOVE NAMED DOCTOR, HIS ASSOCIATES OR ASSISTANTS.

_____ _____
PATIENTS SIGNATURE DATE

_____ _____
DR. GERALD E. DICKSON DATE

DR. GERALD E. DICKSON

NOTICE TO THE PATIENT

Guarantee of Insurance Benefits

We will call your insurance company to obtain your personal coverage and provide you with this information as a courtesy to you.

However, please be aware that the verification of insurance benefits are not a guarantee of payment/coverage. The insurance company considers each claim at the time the claim is received.

We will do our best to give you the most accurate information possible at the time of your first visit.
Due to circumstances beyond our control, we cannot be responsible if we are given the wrong information.

You, as the patient, are responsible for any unpaid portion of your insurance claim. If you have specific questions concerning your coverage, please direct them to your insurance company.

I have read and understand the above information concerning my insurance coverage.

_____ _____

Signature Date

8501 E. MARKET ST. • WARREN, OHIO 44484 • (330) 856-6999

GENTLE CHIROPRACTIC CARE CENTER
DR. GERALD E. DICKSON
8547 EAST MARKET STREET
WARREN, OHIO 44484

X-RAY PREGNANCY RELEASE

This is to certify to the best of my knowledge that I am not pregnant and that the doctor or his staff has my permission to take x-rays.

Please check one:

_____ I am presently using birth control pills or an IUD as a method of birth control or I am within the first 10 days of the onset of the menstral cycle. I will assume all responsibility for any effect on a fetus potentially present.

_____ I am presently not using any form of birth control. I will assume all responsiblity for any effect on a fetus potentially present.

_____ I have had a hysterectomy or tubal ligation preformed on myself and therefore will assume all responsibility for any effect on a fetus potentially present

_____ I am presentally in menopause or am post-menopause. I will assume all responsibility for any effect on a fetus potentially present.

_____ _____

Patient Signature Date