MaximizedLiving

Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT Hamilton Family Chiropractic Center

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Number _____

Number of children: _____ Ages: _____

Name of Emergency Contact: _____ Phone Number _____ Relationship: _____

Insurance Name: _____ Policy Card # _____

Secondary: _____ Policy Card # _____

Please Present insurance card(s) to the front desk, so we can copy them.
Permanent Resident/ Seasonal

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate you're above complaints by ***circling the number***:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

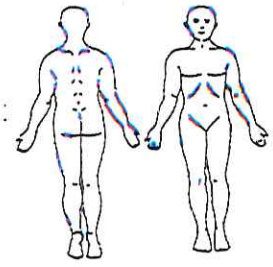
How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes If yes, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

The majority of my patients have experienced dozens of impacts that can cause Vertebral Subluxation. By the time a child can walk they would have fallen 1,000 times. Identify all injuries that your spine has gone through throughout your entire life. This includes: Auto accidents, slips and falls, twists or strains at work, sports or recreational injuries, or injuries at home.

_____

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever had any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for *Never have had*:

__ Migraine Headaches	__ Frequent Colds/Flu	__ Dizziness	__ Menopausal Problems	__ Gall Bladder Problems	__ Rheumatoid Arthritis
__ Headaches	__ Epilepsy	__ Ringing in the ears	__ Bedwetting	__ Anemia	__ Hashimoto's Disease
__ Neck Pain	__ Chest Pain	__ Hearing Loss	__ Liver Problems	__ IBS	__ Fibromyalgia
__ TMJ Pain	__ Venereal Disease	__ Depression	__ Heartburn/Acid Reflux	__ HIV	__ Gouty Arthritis
__ Shoulder Pain	__ Foot or Knee Problems	__ Difficulty Sleeping	__ Heart Problems	__ Fracture	__Crohn's Disease
__ Upper Back Pain	__ Sinus Infections	__ Eating Disorder	__ Heart Attacks	__ High/Low blood pressure	__ Hemorrhoids
__ Mid Back Pain	__ Painful Joints	__ Thyroid Problems	__ Strokes	__ Tuberculosis	__ ADD/ADHD
__ Low Back Pain	__ Skin Problems	__ Prostate Problems	__ Ulcers	__ Psychiatric Problems	__ Shingles
__ Hip Pain	__ Autism	__ Sexual Disfunction	__ Diarrhea/Constipation	__ Bronchitis	__ Menstrual Problems
__ Numbness/Tingling arms, hands, fingers	__ Allergies	__ Digestive Problems	__ Asthma	__ Diabetes	__ Kidney Problems
__ Numbness/Tingling legs, feet toes	__ Joint Replacement	__ Blurred Vision	__ Pneumonia	__ Cancer	__ Arthritis

For Women

Are you nursing? ___Yes ___No Are you taking birth control? ___Yes ___No

Do you experience painful periods? ___Yes ___No Do you have irregular cycles? ___Yes ___No

Do you have breast implants? ___Yes ___No

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

SOCIAL HISTORY

Medications I Now Take:

___Nerve Pills ___Pain Killers (including Aspirin) ___Muscle Relaxers ___Blood Pressure Medicine

___Insulin ___Stimulants ___Blood Thinners ___Tranquilizers

___Other_____

1. **Smoking:** ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage:** consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Coffee:** How many cups/day _____
4. **Recreational Drug use:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
5. **Do you wear:** ___Heels ___Sole lifts ___Inner Soles Arch Soles
6. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Hamilton Family Chiropractic Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Hamilton Family Chiropractic Center for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed

Patient's Name: _____ **Date:** ___/___/___

Hamilton Family Chiropractic Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Colleen Conger, D.C. at (408) 839-0584 if she is unavailable, you may make an appointment with Jessica to see the doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

JDD, DC 5/2011

Patient initials: _____-retaining page 1 of 2

Hamilton Family Chiropractic Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Hamilton Family Chiropractic Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient signature Date

_____ _____

Witness Date

JDD, DC 5/2011

Hamilton Family Chiropractic Center

Michael D Brass D.C.
Colleen Conger-Brass D.C.

What are your life goals and where do you see yourself in the next 10 to 20 years?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

_____ _____

Signature Date