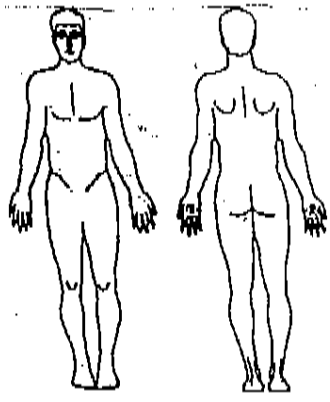
Alliance Chiropractic
4615 Dixie Hwy., Suite A Louisville, KY 40216

Patient Name:_____ Birthdate:_____ Sex: M/F
Address:_____City:_____State:_____Zip:_____
Telephone:_____ Social Security #:_____
Cell Phone:_____ Cell Phone Carrier:_____
Email Address:_____
Occupation:_____Employer:_____Work #:_____
Address:_____City:_____State:____Zip:_____
Insurance:_____ Subscriber Name:_____
Subscriber ID#:_____Group #:_____Spouse Name:_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM
& HOW IT BEGAN:_____



Is this ____Work Related ____Auto Related ____ N/A Date of Onset:_____
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ___No ___Yes Date Taken:_____
Please Check all of the following that apply to you: ____None Apply

No	Yes	No	Yes
☐	☐ History of Recent Infection	☐	☐ Prostate Problems
☐	☐ Recent Fever	☐	☐ Frequent Urination
☐	☐ HIV/AIDS	☐	☐ Pregnancy, # of births___
☐	☐ Diabetes	☐	☐ Abnormal Weight
☐	☐ Birth Control Pills	☐	☐ Visual Disturbances
☐	☐ High Blood Pressure	☐	☐ History of Low/Mid Back Pain
☐	☐ Stroke (date)_____	☐	☐ History of Neck Pain
☐	☐ Dizziness/Fainting	☐	☐ Arthritis
☐	☐ Numbness in Groin/Buttocks	☐	☐ Epilepsy/Seizures
☐	☐ Urinary Retention	☐	☐ History of Tobacco Use
☐	☐ Aortic Aneurysm	☐	☐ Surgeries/Medications:_____
☐	☐ Cancer/Tumor		_____
☐	☐ Osteoporosis		_____

Where you the driver or the passenger? ___Driver ____Passenger

Where was the vehicle hit? ___Front ___Rear ended ___Front right ___front left
___Right side ___Left side ___Rear Right ___Rear left

Vehicle Information? Make:_____ Model_____ Year_____

Head Rest Support Position: ___No head restrain ___High ___Middle ___ Lowest

Head position during crash? ___Straight ahead ___Looking up ___Looking right
___Looking left ___Looking down

Were you wearing a seatbelt? ___Yes ___No ____Only lapbelt

Hand Position during the accident? ___Steering Wheel ___Stick ___Lap ___Other

Did your seat back break during the accident? ___Yes ___NO

Did the airbag deploy? ___Yes ___NO

Did you strike anything in the vehicle? _____

Where you surprised by the impending accident? ___Yes ___No

Where you leaning forward at the time of impact? ___Yes ___No

Where you rendered unconscious? ___Yes ___No

Vehicle Hit: ___My vehicle hit other vehicle/object ___Another vehicle hit mine

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature:_____ **Date:**_____

Alliance Chiropractic

Activities of Daily Living Form

Patient Name: _____ **Date of Birth:** _____

Sex: M_____/ F _____

Pain

___ Bathing
___ Dancing
___ Driving
___ Eating
___ Exercise Class
___ Gardening
___ Going to Church
___ Gym Class
___ Hobbies
___ Household Duties
___ Jogging
___ Mopping
___ Mowing the Lawn
___ Playing Sports
___ Playing with Children
___ Reading
___ Sex

Pain

____ Shopping
____ Sitting
____ Sleeping
____ Social Activities
____ Standing
____ Swimming
____ Tending to Children
____ Tying Shoes
____ Up or Down Stairs
____ Vacuuming
____ Walking
____ Washing Clothes
____ Washing My Hair
____ Weeding
____ Weightlifting
____ Working
____ Working on Computer
____ Yard Work

Other:

_____
_____
_____

Patient Signature: _____ **Date:** _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Alliance Chiropractic
Mehdi Ghayoumi, D.C
4615 Dixie Hwy, Suite A
Louisville, KY 40216

The medical and surgical expense allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

_____
Signature of Policy Holder

_____
Signature of Claimant

_____
Witness

Note: This **"Authorization to Pay Physician"** is valid even where the insurance policy prohibits payments directly to the doctor.

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Patient consent for use and/or disclosure of protected health information to carry out treatment, payment, and healthcare operations.

_____, **hereby states that by signing this Consent, I acknowledge and agree as follows:** The practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the practice to obtain payment for the treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me at my future request. The Practice has further explained my right to obtain a copy of The Privacy Notice prior to signing this Consent. And has encouraged me to read The Privacy Policy carefully prior to singing my Consent.

1) The Practice reserves the right to change its Privacy Practices that are described in this Privacy Notice, in accordance with applicable law.

2) I understand that, and to consent, the following appointment reminders that will be used by the Practice: a) A postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or the individual answering phone.

3) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.

4) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding to this Practice.

5) I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at anytime for future transactions, with the understanding that any such revocation shall not apply to the extent that the Privacy has already taken action in reliance on this consent.

6) I understand that if I revoke this consent anytime, the Practice has the right to refuse to treat me.

7) I understand that the Practice has an open Adjusting Area and agree to such. I also agree to the Practice Policies of the "Welcome Board" located in the front lobby that will include my name as a new patient.

8) I understand that if I do not agree to sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way I can understand.

Signature: _____ **Date:** _____