SEMINOLE CHIROPRACTIC MEDICINE

Confidential Patient Health Record

Today's Date: _____/_____/_____ How did you hear about us? _____

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: _____/_____/_____ Age: _____ Sex: Male/Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Minor Spouse's name (if married): _____

Emergency Contact

Last: _____ First: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other: _____ Phone: _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No If "Yes", what was the date of the accident? _____

What type of accident was it? ☐ Auto ☐ Work ☐ Home ☐ Other Attorney name (if applicable):

_____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Employment/Student Information

Business/School Name: _____ Status: Full-Time Part-Time

Address: _____

City: _____ State: _____ Zip: _____

Work Phone #: _____ Occupation/Title: _____

Insurance Information

Who is responsible for your bill? **YOU** and … (mark appropriate box(es)

☐ Myself ONLY ☐ Spouse ☐ Parent ☐ Workman's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____/_____/_____ Relationship to Patient: _____

Primary Care Physician Name: _____ Phone: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance company, and assign directly to Dr. Son Nguyen, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Doctor(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____/_____/_____

Signature of Patient, Parent, or Guardian | Please print name of Patient, Parent, or Guardian | Date

Personal Health History

List any operations, surgeries, or medical procedures:

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Any current loss of bowel or bladder control: ? Yes ? No Current fever: ? Yes ? No

Any current seizures, paralysis, speech, vision problems: ? Yes ? No

Please list any significant family illnesses: _____

Do you have a family history of:

? Cancer ? Heart problems/Stroke ? Diabetes ? Rheumatoid Arthritis ? High Blood Pressure

Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

Please select one: ? I have never smoked ? Former smoker ? Current smoker, if so how much: ____pk./day

Please select one: ? I don't drink alcohol ? Rarely drink ? Social drinker ? Heavy drinker (_____oz. per day/week)

Have you ever had chiropractic care? ? Yes ? No

If yes, last date of treatment _____ By whom: _____

Similar or different condition: _____ Results: _____

List any medications you currently take: _____

Do you have any allergies? If so, please list: _____

Women Only ? I am ? I am not pregnant

What treatment have you already received for your condition?

? Medications ? Surgery ? Physical Therapy ? Chiropractic Services ? None ? Other:

_____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Epilepsy			Multiple Sclerosis		
Alcoholism			Fractures			Osteoporosis		
Appendicitis			Glaucoma			Pacemaker		
Arthritis			Gout			Parkinson's Disease		
Asthma			Heart Disease			Pinched Nerve		
Bleeding Disorder			Hepatitis			Rheumatoid Arthritis		
Breast Lump			Herniated Disk			Stroke		
Bronchitis			High Blood Pressure			Other		
Cancer			High Cholesterol					
Diabetes			Migraine Headache					

Current Complaint

Why are you here today? _____

_____

List your worst complaint: _____ Date symptoms began: _____

How did it start? _____

How often do you have this pain? _____

Is it ? Constant ? Comes and goes

Is it: ? Improving ? Worsening ? Staying the Same

Is it: ? Mild ? Moderate ? Severe

What worsens it?

? General activity ? Moving wrong ? Bending ? Lifting ? Walking ? Sports ? Getting up from a chair ? Using a computer/desk work ? Other

What makes it better?

? Rest ? General activity ? Ice Packs ? Heating pad ? OTC Meds ? Rx Meds ? Massage ? Chiropractic ? Other

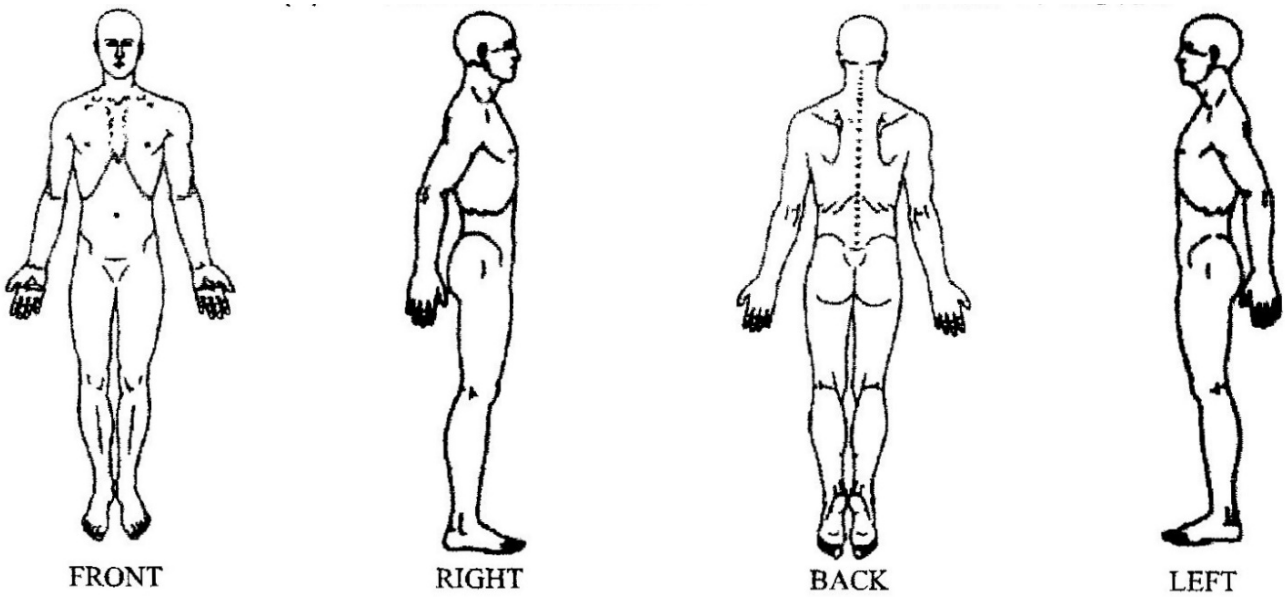
Is it worse in the: ? AM ? PM ? After day wears on ? Steady ? Off and On

Is the symptom:

? Dull/Achy ? Tight/Stiff ? Sharp/Stabbing ? Numb/Tingly ? Shooting ? Burning ? Cramping ? Throbbing

Does it interfere with your: ? Work ? Sleep ? Daily Routine ? Recreation

On the images below, place an X on the areas where you are currently experiencing pain/discomfort.



General/Financial Policy

Welcome to Seminole Chiropractic Medicine. We strive to provide you with excellent Chiropractic care and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any insurance, address, or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, or American Express.
- If you are unable to keep a scheduled appointment, please notify us no later than the day before so that we may offer that time to another patient.
- **There is a $25.00 charge for NO SHOW appointments**.

If you have Health Insurance Coverage: As a courtesy to you, we will attempt to pre-verify your insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not your insurance company. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below, you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions, and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE or MEDICARE Supplemental Patient**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____/_____/_____
Printed Name	Signature of Patient/Legal Guardian	Date

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices.

_____	_____	_____/_____/_____
Printed Name	Signature of Patient/Legal Guardian	Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Son Nguyen, DC and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for Dr. Son Nguyen, DC including those working at the clinic or office listed below or any other office or clinic.

I will have/had an opportunity to discuss with Dr. Son Nguyen, DC and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I understand that I have the right to seek other healthcare professionals for my condition and treatment.

_____ _____ _____/_____/_____
Signature of Patient Printed Name Date

_____
Witness

NON-PREGNANCY VERIFICATION

This is to confirm that I have been advised by the Doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to chiropractic treatment and radiographic pictures.

_____ _____ _____/_____/_____
Signature of Patient Printed Name Date

CONSENT TO TREAT A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED PERSON

I hereby authorize the Doctor to examine and treat as deemed necessary, my _____ (indicate relationship of child).

_____ _____ _____/_____/_____
NAME of Patient Printed Name Date

_____
Signature of Representative

Relationship or Authority of Patient's Representative: _____