

Emerald Coast Chiropractic

Please print clearly and fill in completely

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Date of Birth _____ SSN# _____
E-mail _____
Marital Status (circle one) Single Married Other # of Children _____

Whom may we thank for referring you to our clinic? _____

Your Occupation _____
Your Employer _____ Work Phone _____
Spouse's Name _____
Spouse's Employer _____ Work Phone _____

Insurance Information

Insurance Company _____ Phone Number _____
Member/Subscriber Name _____ ID/Member Number _____

Health History

Give reason for seeking chiropractic care _____

Date of Accident/Onset _____

Is this condition due to a/an (circle one) Auto Accident Work Injury Other

Are you under the care of any other doctor? Yes No If yes, the condition being treated for?

List any current medications: _____

List any past surgeries and dates: _____

List any past accidents and dates: _____

List any x-rays you've had in past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? Yes No

If Yes, Doctor's Name _____ Location _____

Date of last visit _____ Reason for care _____

Are other family members under chiropractic care? Yes No Who? _____

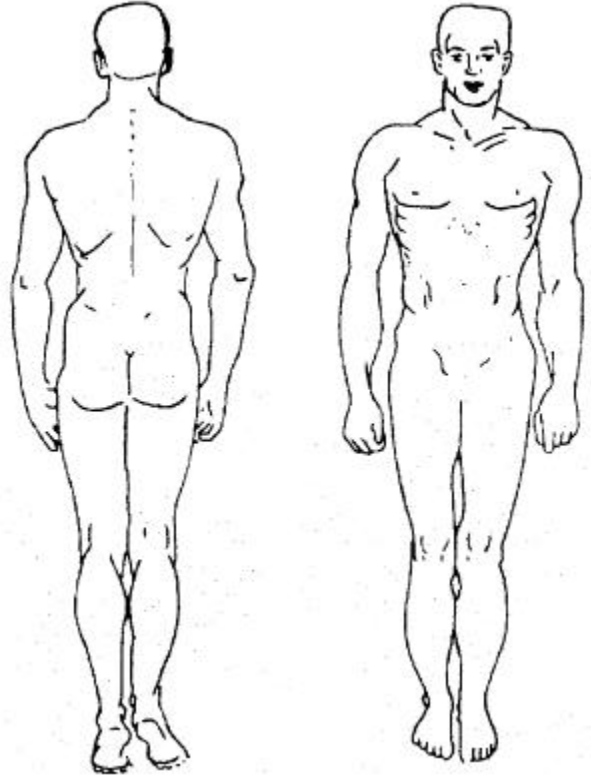
FEMALES: Is there any possibility of you being pregnant? Yes No

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Do you have ?
Headache	<input type="checkbox"/>
Migraines	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>
Numbness	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Nausea	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>
Earaches	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>
Cough	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>
Female problems	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>

Please circle areas of pain or discomfort



Please rate your pain on a scale from 1 to 10

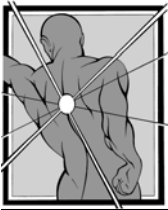
0 1 2 3 4 5 6 7 8 9 10

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank you for being complete and thorough.

Your Signature Below Please

Date: _____



EMERALD COAST CHIROPRACTIC

Kenneth D. Whidden, DC

501-C Highway 98 East
Destin, Florida 32541
850-654-1850

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

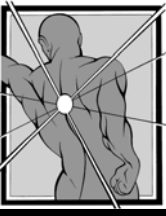
MEDICARE & MEDICAID PATIENT CERTIFICATION - PATIENT'S CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Verification of non-pregnancy:

Date _____ File# _____ X _____
Print Patient's Name

Date of LMP: _____ X _____
Patient's Signature

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. X _____
If other than patient, print name & relationship



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CHIROPRACTIC**

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**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient name (please print)

Date

Parent, guardian or patient's legal representative

Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART
AND MAINTAINED FOR SIX YEARS.**