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? ______________

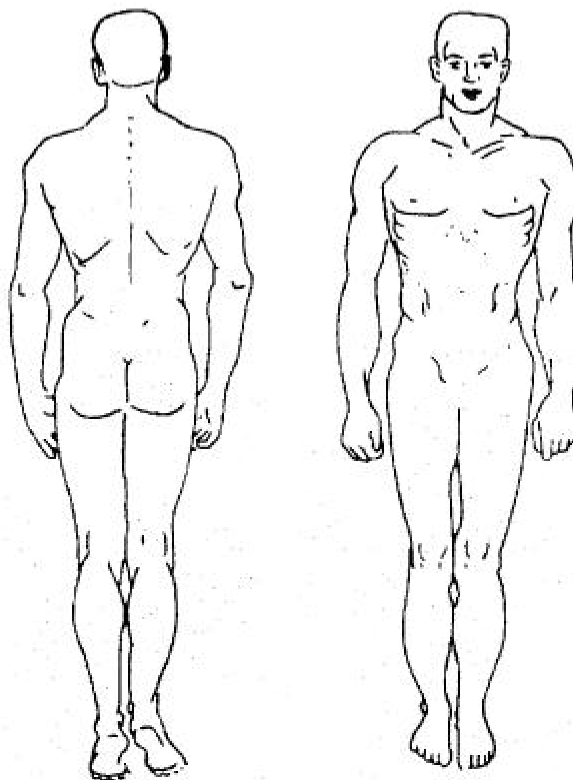
FEMALES: Is there any possibility of you being pregnant? Yes No

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	❑
Migraines	❑
Neck Pain	❑
Shoulder Pain	❑
Arm/Hand Pain	❑
Mid Back Pain	❑
Low Back Pain	❑
Hip Pain	❑
Leg/Foot Pain	❑
Disc Problems	❑
Arthritis	❑
Other joint pain	❑
Numbness	❑
Joint Swelling	❑
Dizziness	❑
Nausea	❑
Weakness	❑
Fatigue	❑
Nervousness	❑
Insomnia	❑
Heart Problems	❑
Vision Changes	❑
Nose Bleeds	❑
Ringing in Ears	❑
Earaches	❑
Hearing Loss	❑
Cough	❑
Chest pains	❑
Female problems	❑
Allergies	❑
Asthma	❑
Cancer	❑
Osteoporosis	❑
Diabetes	❑
Hypoglycemia	❑
Digestive problem	❑
Urinary Problems	❑
Frequent colds	❑
Skin conditions	❑

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.

____

____

____

____

____

____

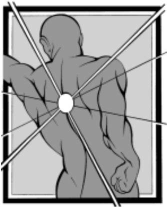
____

Thank you for being complete and thorough.

Your Signature Below Please

____

Date: ______________________



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#___________

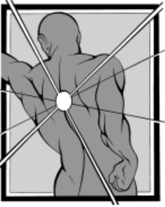
X______________________________________
Print Patient's Name

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



EMERALD COAST
CHIROPRACTIC

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

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.

SUBMIT