Brandon Chiropractic Health Center
Preventative Family Health Care

It's all about optimal function!

*Patient Name:*_____ *Date:*_____
*DOB:*_____ *Age:*_____ *Sex:* _____*Male* _____*Female*
Address: _____ *City:*_____ *State:*_____ *Zip:*_____
*Home #:*_____ *Office #:*_____ *Cell #:*_____
*Email:*_____
Whom may we thank for referring you?_____

Responsible Party

*Name of Person Responsible for Account*_____
*Relationship to Patient*_____ *Phone #:* _____
Address (if not same as above): _____
*Name of Employer:*_____ *Work #:* _____

Insurance Information

*Name of Insured:*_____ *Relationship to patient*_____
Insurance Company: _____ *Phone #:* _____
Policy ID: _____ *Group #:*_____
*Insurance Co. Address*_____
*Deductible amount?*_____ *Co-pay amount?*_____ *Max Annual Benefit?* _____

Certification And Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly.
To Brandon Chiropractic 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 above named organization may use my health care information and may disclose such information to the above named insurance carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent/Guardian or Personal Representative ***Date***

_____ _____
Print Name of Patient, Parent/Guardian or Personal Representative ***Relationship to patient***

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Please fill out the following information regarding your chief complaint and health history.

Present Health Challenge(s):

What brings you in to the clinic today?

_____

How long have you had this issue?

_____

How severe do you feel this issue is? How much pain are you in?

0 Very Little Pain	1	2	3	4	5	6	7	8	9	10 Most Severe Pain

What have you tried to help? Has it worked?

_____

_____

Is this injury the result of an auto accident? Y / N Or is this the result of an injury at work? Y/ N
If yes please describe what happened below

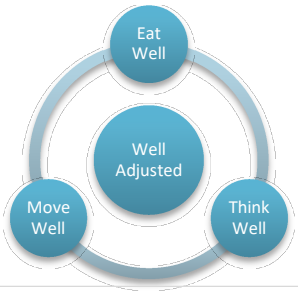
_____

_____

Are you interested in learning about: □Living a healthier life....□ No thanks, I'm just here for symptom care.

Please check any and all other health issues:

____ Allergies	____Frequent colds/ Congestion/ Flu	____Stoke or Seizures	____Asthma
____Ear infections	____Infected/sore Throat	____Arthritis	____Cough /Bronchitis
____Sinus Issues	____Acid Reflux/GERD	____Urinary tract infections	____Poor appetite/ Ulcer
____Poor digestion/ (constipation/diarrhea)	____Headaches	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD/SPD
____Irregular sleep Patterns	____Heart Disease/ High Blood Pressure	____Urinary Incontinence	____Over Weight
____Anxiety/ Depression	____Mood swings	____Cancer/ Tumors	Other:_____



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HIPAA

I give Brandon Chiropractic Health Center my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Brandon Chiropractic Health Center is not required to agree to the request. If Brandon Chiropractic Health Center agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature:_____Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient_____