# New Patient Health History Form

**In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.**

## Patient Data

First Name ______ Last Name ______ Date ______ Email* ______

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

## Mailing address

Address ______ City ______ State ______ Zip ______

Telephone (Work) ______ (home) ______ Referred By ______

Age ______ Birth Date ______ Social Security # ______ Number of Children ______

Occupation ______ Employer ______

Marital Status ______ Spouse's Name ______ Spouse's Occupation ______

Spouse's Employer ______ Spouse's Health Status ______

Emergency Contact ______ Phone ______

## Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe: ______

Date if Injury ______ Date symptoms appeared ______

Have you ever had same condition? ◯ No ◯ Yes If yes, when? ______

List of other practitioners seen for this injury/condition ______

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe ______

## Insurance Information

Name of party responsible for payment ______ Phone ______

Do you have health insurance? ◯ No ◯ Yes Name of company ______

*** If an auto accident, please provide:**

Insurance Company Name ______ Contact Person ______

Phone: ______ Claim # ______

## Signatures

Name of the insured ______

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ______ Date ______

Spouse's or guardian's signature ______ Date ______

© Copyright 2005 ChiroMatrix

## Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes  If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)l

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

| Have you ever: | No | Yes | Briefly Explain |
|---|---|---|---|
| Broken bones? | ◯ | ◯ | |
| Been hospitalized? | ◯ | ◯ | |
| Been in an auto accident? | ◯ | ◯ | |
| Had Sprains/Strains? | ◯ | ◯ | |
| Been struck unconscious? | ◯ | ◯ | |
| Had surgery? | ◯ | ◯ | |

## Family History

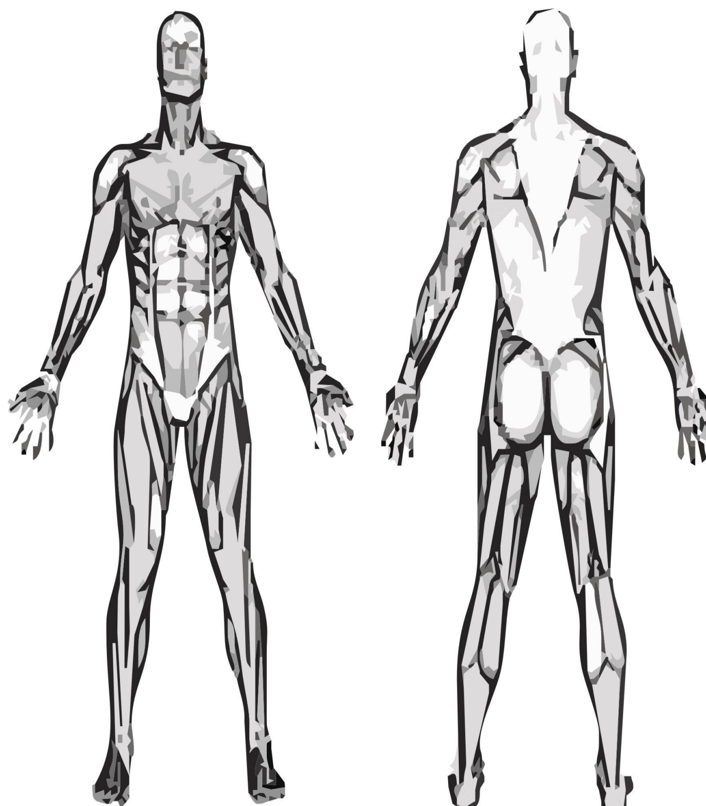
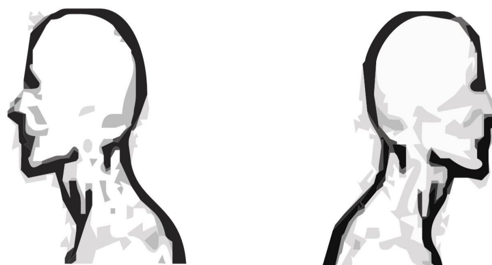
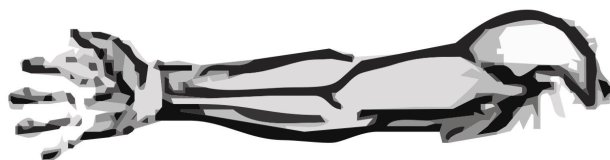
**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

| Question | No | Yes |
|---|---|---|
| Do you experience pain every day? | ◯ No | ◯ Yes |
| Do your symptoms interfere with daily life? | ◯ No | ◯ Yes |
| Does pain wake you up at night? | ◯ No | ◯ Yes |
| Are your symptoms worse during certain times of the day? | ◯ No | ◯ Yes |
| Do changes in weather affect your symptoms? | ◯ No | ◯ Yes |
| Do you wear orthotics? | ◯ No | ◯ Yes |
| Do you take vitamin supplements? | ◯ No | ◯ Yes |

What activities aggravate your symptoms?

| Habits | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Alcohol | ◯ | ◯ | ◯ | ◯ |
| Coffee | ◯ | ◯ | ◯ | ◯ |
| Tobacco | ◯ | ◯ | ◯ | ◯ |
| Drugs | ◯ | ◯ | ◯ | ◯ |
| Exercise | ◯ | ◯ | ◯ | ◯ |
| Sleep | ◯ | ◯ | ◯ | ◯ |
| Appetite | ◯ | ◯ | ◯ | ◯ |
| Soft Drinks | ◯ | ◯ | ◯ | ◯ |
| Water | ◯ | ◯ | ◯ | ◯ |
| Salty Foods | ◯ | ◯ | ◯ | ◯ |
| Sugary Foods | ◯ | ◯ | ◯ | ◯ |
| Artificial Sweeteners | ◯ | ◯ | ◯ | ◯ |

© Copyright 2005 ChiroMatrix

| Have you ever suffered from: | |
|---|---|
| ☐ Alcoholism<br>☐ Allergies<br>☐ Anemia<br>☐ Arteriosclerosis<br>☐ Arthritis<br>☐ Asthma<br>☐ Back Pain<br>☐ Breast Lump<br>☐ Bronchitis<br>☐ Bruise Easily<br>☐ Cancer<br>☐ Chest Pain/Conditions<br>☐ Cold Extremities<br>☐ Constipation<br>☐ Cramps<br>☐ Depression<br>☐ Diabetes<br>☐ Digestion Problems<br>☐ Dizziness<br>☐ Ears Ring<br>☐ Excessive Menstruation<br>☐ Eye Pain or Difficulties<br>☐ Fatigue<br>☐ Frequent Urination<br>☐ Headache<br>☐ Hemorrhoids<br>☐ High Blood Pressure<br>☐ Hot Flashes<br>☐ Irregular Heart Beat<br>☐ Irregular Cycle<br>☐ Kidney Infection<br>☐ Kidney Stones<br>☐ Loss of memory<br>☐ Loss of balance<br>☐ Loss of smell<br>☐ Loss of taste<br>☐ Lumps In Breast<br>☐ Neck Pain or Stiffness<br>☐ Nervousness<br>☐ Nosebleeds<br>☐ Pacemaker<br>☐ Polio<br>☐ Poor Posture<br>☐ Prostate Trouble<br>☐ Sciatica<br>☐ Shortness of breath<br>☐ Sinus Infection<br>☐ Sleep problems or Insomnia<br>☐ Spinal Curvatures<br>☐ Stroke<br>☐ Swelling of ankles<br>☐ Swollen Joints<br>☐ Thyroid Condition<br>☐ Tuberculosis<br>☐ Ulcers<br>☐ Varicose Veins<br>☐ Venereal Disease<br>☐ Other: ______ | Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.<br><br>**A**=Ache **O**=Other<br>**B**=Burning **P**=Pins & Needles<br>**N**=Numbness **S**=Stabbing<br><br><br><br> |

© Copyright 2005 ChiroMatrix

Absolute Wellness Center
Rick C. White, DC

# FINANCIAL POLICY

My primary responsibility is to help my patients' experience better health and I wish to spend my time and energy toward that end. In the interest of maintaining a solid health care practice, I feel it is important to establish a clear financial policy to avoid any misunderstandings.

- Payment is due at the time of your visit unless satisfactory arrangements are made in advance.
- There is a 24 hour cancellation policy. You will be charged a no show fee of $50.00.
- Insurance: As a courtesy we will bill you insurance company. However you are ultimately responsible for your bill. Should your insurance deny coverage we will be happy set up a payment plan so that you may continue your care.
- Some insurance companies do not cover Chiropractic or chiropractic related services please have due diligence and confirm your benefits.
- All ancillary products are paid for at time of service unless other arrangements are made.
- We accept Visa/ Master Card, checks and cash.

Personal Injury/ Auto Insurance

> Regardless of who the responsible party is, a claim will be established with your insurance company. Please contact you agent to expedite the claim process. You are still personally responsible for your bill but will not be required to pay as services are rendered. (If our office has not received payment, from your insurance carrier, within 60 days you will be responsible for the balance of the bill.

Workers' Compensation

> You are required to complete an accident report on your first visit to establish a claim. You are not personally responsible for the account unless your claim is partially or totally denied by Workers' Compensation Insurance. In such cases payment for services rendered is your responsibility.

I have read and understand the policies as described above. I understand I am responsible for payment of all services provided by Absolute Wellness Center. I agree to make payment in full at time of service, unless other arrangements have been made. I understand that if payment has not been made within 90 days of the date of service and no financial arrangements have been made there will be collection expenses incurred at a rate of 19.8% APR. In addition should this account be turned over to collections I will pay a 40% collection fee.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature: _______________________________________________________ Date: ________________

# Absolute Wellness Center

**Rick C. White, D.C.**
**1524 Willamette Street Eugene, Oregon 97401**
**Phone (541) 484-5777**

## NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosure

The Absolute Wellness Center may collect protected health information from you for the purposes of coordinating treatment, payment or other health care services plan operations. Health care services plan operations including quality management utilization review, claims payment and provider credentialing activities. The Absolute Wellness Center may also collect your protected health information as required by industry or government regulators, such as the U.S. Department of Health and Human Services, and clinical or professional licensing accreditation entities. The Absolute Wellness Center may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. As required, the Absolute Wellness Center may also disclose protected health information to the sponsor of your health plan.

Authorization

Any uses or disclosures other than those described in the “Uses and Disclosure” section above will be made only with your authorization. In the event you authorize the Absolute Wellness Center to use or disclose your protected health information in ways other than those described above, you have the right to revoke that authorization at any time. To revoke such an authorization you must send written notice or revocation to the Absolute Wellness Center at the address listed above.

Statement of Individual Rights

**Right To Request Restrictions On Uses and Disclosure of Protected Health Information:** You have to right to request restrictions on the use and disclosure of your protected health information. To request a restriction you must submit a written request explaining, in detail, the requested restriction. Upon receipt of such a request, the Absolute Wellness Center will discuss the requested restriction with you. Please note that while you may request a restriction, Absolute Wellness Center has the right to refuse the request. Additionally, as allowed by law, the Absolute Wellness reserves the right to override any such restrictions in emergency health care situations. You may terminate an agreed upon restriction at any time by giving the Absolute Wellness Center a verbal or written request to terminate the restriction. If Absolute Wellness Center unilaterally terminates an agreed upon restriction, the Absolute Wellness Center will inform you of the termination and can share only the information generated after the termination of that restriction.

**Right To Receive Confidential Communications:** You have the right to receive confidential communications, including the right to direct where communications containing health information sent to you. To verify or specify where you would like such communications sent to you please communicate your preferences to the Absolute Wellness Center.

**Right To Inspect And Copy Protected Health Information:** You have the right to inspect and copy your protected health information that is maintained by the Absolute Wellness Center. To request, to inspect or

to copy you protected health information, please communicate your request to the Absolute Wellness Center.

**Right To Amend Protected Health Information:** You have the right to amend your protected health information that is maintained by the Absolute Wellness Center. To amend your protected health information, please communicate your request to the Absolute Wellness Center.

**Right To Receive An Accounting of Disclosures Of Protected Health Information:** You have a right to receive an accounting of any disclosures of your protected health information that were made for purposes other than coordinating treatment, payment or other health care services plan operations. To request an accounting of any such disclosures, please communicate your request to the Absolute Wellness Center.

## Entity Requirements Under Law

The Absolute Wellness Center has a legal requirement to maintain the privacy of your protected health information. The Absolute Wellness Center has a legal requirement to provide you with this notice of his/her duties and privacy practices and to abide by the terms of this notice.

## Reservation Of Right To Revise Privacy Practice

The Absolute Wellness Center reserves the right to charge and revise its privacy practices relating to protected health information. If the Absolute Wellness Center changes or revises its privacy practices the Absolute Wellness Center will provide you with a revised notice.

## Complaint Procedure

If you believe that your protected health information has been improperly used or disclosed, you may file a complaint with the Absolute Wellness Center. To file such a complaint you should contact the office manager at the telephone number listed above. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services (DHHS). There are no penalties or other retaliations for filing any complaints regarding the improper use or disclosure of protected health information.

Effective Date & List Of Entities To Whom This Notice Applies

This notice goes into effect on April 14, 2003. This notice applies to Rick White/ Absolute Wellness Center. Absolute Wellness Center will share your protected health information only for the purpose of treatment, payment and health care operations.

---

Patient Name Patient Signature Date