Confidential Patient Information Sheet

Full Name: ____ Date: ___ / ___ / ___

Date of Birth:____/____/____ Sex: Male / Female Age: _____ Height: __________ Weight___________

Home Address:____City:_________________State:______ Zip: _______

Home Phone: ____________________ Cell Phone:____________________ SS#:_________________________

Email:____ Preferred Language: ____________________

Preferred communication for Appt. reminders: Email / Phone Call / Text / Mail Cell Phone carrier: _____________

Employer Name: ___________________ Phone No. (____) ____________ Occupation/Work Duties: _____________

How or Whom did you hear about our office? ____

FAMILY: Married____ Single____ Widowed____ Divorced____ Spouse Name: ____________________
Spousal Occupation: __________________ **Children name with ages:**____________________________________

EMERGENCY: (Name of nearest relative or friend not living with you)
Full Name: ____ Phone Number_________________

Race: White (Caucasian), Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, I Decline to Answer. **Ethnicity:** Hispanic or Latino, Not Hispanic or Latino, I Decline to Answer

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Chiropractors / Nutritionists you have seen before:
Name _________________________________ City ________________ State _______ When ___________
Name _________________________________ City ________________ State _______ When ___________
Name _________________________________ City ________________ State _______ When ___________

List Medical doctor seen within past few years:
Name _________________________________ City ________________ State _______ When ___________
Name _________________________________ City ________________ State _______ When ___________
Date of last physical examination: ___________________________

List all Surgeries / Therapies / Diseases:
Type ____ When: ___________
Type ____ When: ___________
Type ____ When: ___________
Type ____ When: ___________

Past Accidents / Injuries / Hospitalizations:
Type: ____ When: __________ Hospitalized? Yes ___ No___
Type: ____ When: __________ Hospitalized? Yes ___ No___
Type: ____ When: __________ Hospitalized? Yes ___ No___

List all Medications / Birth Control/ Pain Relievers / Vitamins / Herbs you are currently taking:
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______
Type: _______________________________________ For: _________________________ How Long:_______

Traumatic Birth: Yes / No Explain: ____
Vaccination Reactions: Yes / No Explain: ____

Medication Allergic Reactions: ____
Food/Environmental Allergies:____
Smoking Status: Every Day Smoker, Occasional Smoker, Former Smoker, Never Smoked **Start Date**: _________

Goals For Your Care: People are patients of our office for a variety of health reasons. Dr. Rich will assess your needs and desires with your current health status when recommending a care plan. Please check the type of care you desire so that we can be guided to meet your health care wishes.

- ☐ **Relief Care: Symptomatic relief of pain and discomfort with chiropractic and/or nutritional care.**
- ☐ **Corrective Care: Correcting the cause of the problem as well as the symptom with chiropractic and/or nutritional care.**
- ☐ **Wellness Care: Care to achieve your optimal health through chiropractic and nutritional care.**

CONSENT FOR CHIROPRACTIC CARE AND NUTRITIONAL CARE

The **primary practice objective** of Fetcho Family Chiropractic, L.L.C. is to help restore and maintain **HEALTH** by reducing **SUBLUXATIONS** with **CHIROPRACTIC ADJUSTMENTS** and support the **physiological and biomechanical processes of the body with Nutritional Support.** We do not diagnose or treat any disease or condition other than subluxations (spinal and extremities.) If, however, during the course of chiropractic care we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

RELEASE OF INFORMATION: We want you to know how your **Patient Health Information** is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS: I hereby instruct and direct the payment of all professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy to Fetcho Family Chiropractic L.L.C as payment for professional services rendered.

BILLING INFORMATION: Your insurance policy is a contract between you and your carrier. Many policies reimburse for at least some chiropractic care, but coverage varies from policy to policy and is constantly changing. **You understand and agree that you are responsible for all charges not paid by your insurance company.** Account balance or estimated co-pay is due at the time of service. If insurance payment quote is different from actual insurance payment you will be notified as soon as possible, and difference will be refunded or additional payment will be required promptly. Your account also will be charged $25 for returned checks. Should your account become delinquent, you will be responsible for any interest (to accrue at a rate of 18% annually, commencing 30 days after the initial bill for services is issued), for collection fees, including but not necessarily limited to attorney's fees and court costs incurred in collection attempts on your account.

FEMALE PATIENTS ONLY: Pregnant: Yes. If pregnant no X-ray Exam will be performed. **No**. I am not pregnant, nor is pregnancy suspected at this time. This office has permission to perform an X-ray Exam on me. I have been advised that X-ray can be hazardous to an unborn child and that 10 days following the onset of a menstrual period are generally considered to be safe for X-ray Exam.

NUTRITIONAL INFORMED CONSENT: According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.* A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy. Although, a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

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). If I lapse in my care for an extended period of time, or have new accidents or changes in my health status, additional examinations may be required to update my history and health status before further care can continue. It will be determined by the doctor at that time.

I, the undersigned, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic and nutritional care on this basis. My signature indicates that I accept financial responsibility for my care and consent to Fetcho Family Chiropractic, L.L.C. use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I am the patient or legal guardian listed on this form.

☐ **I chose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient's Name ____

Signature ____________________________________ **Date:** ____________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________ Relationship to Patient: ____________