DEAN'S CHIROPRACTIC CENTER

1225 S. Main St. Suite 201, Greensburg PA 15601 Phone: 724-836-7246 Email: DeansChiropractic@gmail.com

PATIENT INFORMATION

Welcome to Our Office

Patient Name_____**Date of Birth**_____**SS#**_____

Address_____**City**_____**ST**_____**Zip**_____

Home Phone_____**Cell**_____**Work Phone**_____

☐ **Male** ☐ **Female** **Email Address**_____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Employer Name_____**Occupation**_____

Spouse's Name_____**Date of Birth**_____

Emergency Contact Name_____**Phone**_____**Relationship**_____

How were you referred to us?_____

Primary Care Doctor:_____

Previous Chiropractor_____**Why are you changing?**_____

❑ NONE	MEDICATION NAME	DOSAGE	What are you taking it for?

❖ **If more than 5 medications, list on back of form**

❑ NONE	LIST SURGERIES OR ACCIDENTS/ INJURIES	WHEN

❑ **NONE** **ALLERGIES** **List ALL allergies**_____

Smoking Status: (Circle one) Never Smoked Former Smoker Smoker ____ packs day **Alcohol:** None Social _ _____drinks/ week

Exercise: Excellent Good Poor **Diet:** Excellent Good Poor **Sleep:** Excellent Good Poor **Water Intake** Excellent Good Poor

Complaint _____

Started When_____

Cause of Pain_____

Pain is ○ Aching ○ Sharp ○ Deep ○ Numbness and Tingling _____

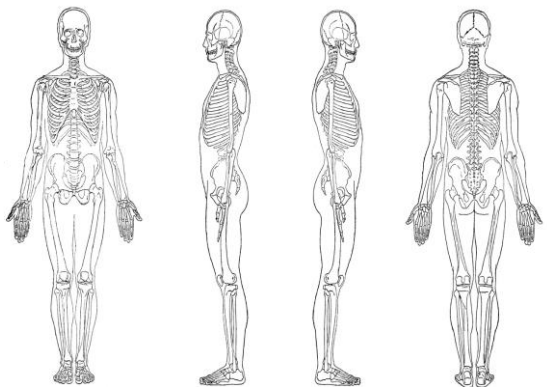
Does pain go down your arm or leg? ○ No ○ Yes_____ left or right

From 0-10 (0 no pain and 10 being the worst pain) Yours is _____/10

Pain is ○ Constant ○ Frequent ○ Occasionally ○ Intermittently
(100-76%) (75-51%) (50-26%) (25-0%)

What makes it worse?_____

What gives you relief?_____



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Name: _____ **Date**_____

☑ **Check the boxes that apply to you.**

REVIEW OF SYSTEMS

❑ **None I have reviewed this entire page and NONE of the following conditions listed below apply to me.**

❑ None CONSTITUTIONAL	Past	Now
Lack of Energy		
Unexplained weight gain		
Unexplained weight loss		
Diagnosis of Cancer		
❑ None EENT	**Past**	**Now**
Frequent Sinus Infections		
Frequent Colds		
Deafness		
Earaches		
Chronic Sinus Infections		
Ringing in ears		
Swallowing Problems		
❑ None GASTROINTESTINAL	**Past**	**Now**
Gallbladder Problems		
Constipation		
Diarrhea		
Indigestion		
Excessive hunger		
Poor Appetite		
❑ None PSYCHIATRIC	**Past**	**Now**
Frequent Sadness		
Mood Swings		
Suicidal Thoughts		
Phobias/ Unexplained Fears		
❑ None SKIN	**Past**	**Now**
Bruise Easily		
Very Dry Skin		
Hives / Rash		
Itching		
Varicose Veins		
Skin boils or lesions		
❑ None NEUROLOGIC	**Past**	**Now**
Frequent headaches		
Tremors / Hands shaking		
Stroke		
Seizures / Convulsions		
Double Vision		

❑ None CARDIOVASCULAR	Past	Now
Heart Disease		
Shortness of Breath		
Heart Palpitations		
Heart Murmur		
Ankle Swelling		
Chest Pain		
Pain in Legs with Walking		
❑ None RESPIRATORY	**Past**	**Now**
Chronic Cough		
Difficulty Breathing		
Wheezing		
❑ None ENDOCRINE	**Past**	**Now**
Excessive Thirst		
Low Blood Sugar (hypoglycemia)		
High Blood Sugar (hyperglycemia)		
Shortness of Breath		
Adrenal Dysfunction		
Unexplained Hair Loss		
Excessive Fatigue		
❑ None GENITO-URINARY / LIVER	**Past**	**Now**
Frequent Bladder Infections		
Kidney Stones		
Painful Urination		
❑ None MUSCULOSKELETAL	**Past**	**Now**
Arthritis		
Hernia		
TMJ (Jaw Pain)		
Bursitis		
Joint Swelling		
❑ None FEMALES ONLY	**Past**	**Now**
Hot Flashes		
Excessive Menstrual Flow		
Headaches around Menses		
Breast Pain		
Fibroids		
Frequent Yeast Infections		
Excessive Fatigue		

❑ None MEDICALCONDITIONS	Past	Now
Alcoholism		
AIDS/ HIV		
Anemia		
Anxiety		
Asthma		
Arthritis		
High Blood Pressure		
Low Blood Pressure		
High Cholesterol		
Cancer		
Diabetes Type 2		
Diabetes Type 1		
Diverticulitis		
Depression		
Eczema		
Epilepsy		
GERD		
Heartburn		
Hiatal Hernia		
Hemorrhoids		
Heart Attack		
Heart Murmur		
Herpes		
Hepatitis A B C		
Irritable Bowel Syndrome		
Inguinal Hernia		
Mitral Valve Prolapse		
Osteoporosis		
Pneumonia		
Rheumatoid Arthritis		
Stroke		
Thyroid - Hypothyroid		
Thyroid - Hyperthyroid		
Ulcers		
Anything else not listed:		
❑ None ALLERGIES	**Past**	**Now**
Seasonal		
Latex		
Penicillin		
Sulfa Drugs		
Bee Stings		

Patient Initials_____

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Patient Name X_____

(Printed)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or declined your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payments and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list the name(s) who we may share your medical information with: ❑ **None**

Spouse/Partner_____Parent_____Child_____

X_____ _____

Patient / Guardian Signature **Date**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Chiropractor(s) who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the Chiropractor(s) at Dean's Chiropractic Center LLC.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

X_____ _____

Patient / Guardian Signature **Date**

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Patient Name X_____
(Printed)

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dean's Chiropractic Center, 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 herby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____
Patient / Guardian Signature **Date**

TEXT / EMAIL MESSAGE ACCOUNT ALERTS

I authorize DEAN'S CHIROPRACTIC CENTER, LLC to send text /email message appointment reminders to me on my provided cell phone number or email address. I understand that I may reply with various commands to receive account information such as appointment reminders, schedule next appointment, patient satisfaction surveys, health tips and communicating new services or products. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply. It is important to note that text or email communications are not always secure. Text messages and emails can be intercepted and for this reason, we do not communicate personal health information through this method.

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text or email messaging services. I understand that this authorization can only be revoked in writing.

X_____ _____
Patient / Guardian Signature **Date**

MISSED APPOINTMENT / NO SHOWS

A "no show" is someone who misses an appointment without canceling it in an acceptable manner. When a patient does not show up for their appointment, we lose the opportunity to see and help someone else. A missed appointment will be recorded in the "patient's file. The first time there is a "no show", there will be no charge. Any additional "no show" will result in a fee of $40 being billed to the patient's account. "No show" fees are the patient's responsibility and must be paid before your next appointment. The fee cannot be billed to your insurance company.
Multiple "No Shows" in any 12 month period will result in termination from our practice. Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

X_____ _____
Patient / Guardian Signature **Date**