APPLICATION FOR CARE

Welcome to our office. Please print and thoroughly complete <u>all</u> questions and return to front desk. Please know all information is kept confidential. Thank you.

Name: _____Today's Date: _____ (Patient ID # _____office use)

Address: _____City/State/Zip: _____

E-Mail: _____

Phone: (H) _____ (W) _____(C): _____

Marital status: S M W D Birth date: ____/____/____ Age: _____

Occupation:_____ Employer/Company:_____

Who may we thank for referring you? _____

Please check all social media platforms that you have seen our practice on:

___ Website ___Google ___ FB ___Instagram ___ Zoom (Wellness Workshop)

Spouse's name: _____Occupation: _____

Children's names & ages: _____

Past DC (Doctor of Chiropractic):_____Last DCvisit: _____

Primary Care Providers Name (MD / DO):_____Town_____
Date of last visit: _____ Purpose of visit:_____

Please list any specialists seen (Drs. Name):
Name: _____Last visit:_____Purpose:_____
Name: _____Last visit_____Purpose:_____

Hobbies/activities:

_____

Hours of exercise per week: _____ what do you do? _____

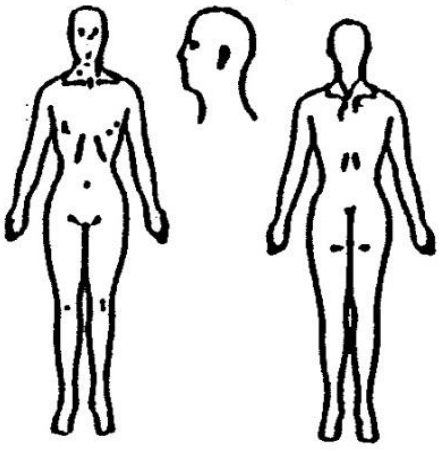
Hours of work per week: _____ Do you smoke?_____ If yes,PPD_____ How many years?_____

Please list all current health problems, issues, and challenges and or symptoms

1. _____2. _____ 3. _____

4. _____5. _____ 6. _____

<u>Please mark problem areas>>></u>



Please list any auto accidents / work/ sport injuries and date?

_____

_____

Is your current condition(s) due to any or auto accident? YES NO IF YES, STOP *NOTIFY STAFF*

Do you have an attorney? If yes, please provide Name, Address and Phone # _____

_____

Please note when was the last time you experienced same or similar symptoms or conditions as now?

_____

Check off family members with same or similar health problems:
___grandparents (GM/ GF), ___father, ___mother, ___brother, ___sister ___children
Explain:_____

Spinal X-Rays, MRI, or CT: Note date, facility, body part, and result: _____

_____

_____

Please list any additional medical procedures or surgery you have had. Note when and for what reason.

_____

_____

Have you ever been diagnosed or treated for cancer, heart disease, or any other chronic disease? No Yes
If yes,please explain:

_____

Do you know what a "Spinal Subluxation" is? No If yes, please describe

_____

Do you have or ever been shown any daily "Spinal Hygiene"program to do at home, that you presently practice? No Yes
If Yes, please explain:_____

(Women) Is there any possibility that you are pregnant? _____ Last cycle date_____ Initial_____

How will you be paying for today's visit? ___ Cash ___Check ___Debit card ___Credit card

The above information is true and accurate to the best of my knowledge. My reason for consultation with Dr. Gurman is for evaluation of my physical health and the potential for improvement. I understand that I am personally financially responsible for all services I receive. Benefit Disclaimer
I UNDERSTAND THAT THE USE OF MY INSURANCE VERIFICATION INFORMATION DOES NOT GUARANTEE PAYMENT OF ANY HEALTH CARE CLAIM BY MY INSURANCE CARRIER AND SUCH INFORMATION IS SUBJECT TO CHANGE, EVEN RETROACTIVELY, AT ANY TIME BY THE INSURANCE CARRIER. I UNDERSTAND AND AGREE TO BE PERSONALLY RESPONSIBLE FOR SERVICES RECEIVED FROM WESTWOOD FAMILY CHIROPRACTIC, DR GURMAN.

_____ _____ _____
Patient or Guardian Signature **Date** **Staff (initial)**

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program
CMS requires providers to report both race and ethnicity

- First Name:_____ **Last Name**:_____

- Email address: _____@_____ **DOB:** __/__/____

- Preferred Language: _____ Gender (Circle one): Male / Female

- Smoking Status (Check one):

___Every Day Smoker
___Occasional Smoker
___Former Smoker
___Never Smoked

-Height: ____' ____'' **Weight**:_____ **Blood Pressure**:_____ /_____

- Race (Check one):

___American Indian or Alaska Native
___Asian
___Black or African American
___White (Caucasian)
___Native Hawaiian or Pacific Islander
___Other
___I Decline to Answer

-Ethnicity (Check one):

___Hispanic or Latino
___Not Hispanic or Latino
___I Decline to Answer

- Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

- Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose 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 Signature: _____ Date:_____

WESTWOOD FAMILY CHIROPRACTIC

AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature

Description of personal representative's authority to act for the patient