Please initial each page and sign at the end.

GENERAL INFORMATION

Last Name: ________________________First________________________ ☐ Male ☐ Female SS#: ___________________

Address: ____ City: ________________ State: _______ Zip: __________

Email Address_______________________________________ Cell Phone: ________________ Work Phone: ________________

Home Phone: ________________Date of Birth: ___________ Marital Status (circle one): S M W D #Children_______

Employer Name: _______________________________________ Employer Address: _____________________________________

Occupation: ____ Hobbies/Interests:_______________________________________

HEALTH INSURANCE INFORMATION (all patients)

☐ I am covered by health insurance. ☐ I am not covered by health insurance.

Name of Health Insurance Company: ____

Name of Insured: ____ Insured is: ☐ Self ☐ Spouse ☐ Parent

Insured DOB: ____ Insured SS#: __________________________________

ID number: ____ Policy or group number: __________________________

AUTO INSURANCE INFORMATION (if this is the result of a car accident)

Name of your car insurance company: ____

Name of the insured: ____ Date of the accident: ___________________

Name of claims adjuster: ____ Claim number: ________________________

Name of other party involved: _____________________________________ Other party's insurance company:

PATIENT HEALTH INFORMATION

Please check any of the following conditions that apply to you now, or have applied to you in the last six months.

☐Headaches	☐Loss of taste	☐Pins& needles in arms/legs	☐Insomnia	☐Fever
☐Loss of concentration	☐Pain behind eyes	☐Right/left arm pain	☐Irritable	☐Stomach upset
☐Light bothers eyes	☐Neck pain	☐Right/left leg pain	☐Difficulty breathing	☐Constipation
☐Loss of memory	☐Neck stiffness	☐Right/left shoulder pain	☐Anxiety	☐Diarrhea
☐Head seems heavy	☐Pain with chewing	☐Right/left wrist pain	☐Fatigue	☐Menstrual problems
☐Dizziness/fainting	☐Upper back pain	☐Right/left elbow pain	☐Sleep difficulties	☐Fingers/toes numb
☐Ringing in ears	☐Mid back pain	☐Right/left ankle pain	☐Sinus trouble	☐Cold hands/feet
☐Buzzing in ears	☐Lower back pain	☐Right/left knee pain	☐Depression	☐Arthritis
☐Loss of smell	☐Chest pain	☐Pain in hips	☐Nausea	☐Anemia
☐Loss of balance	☐Shortness of breath	☐Pain in tailbone	☐Hypertension	☐Jaw pain/TMJ

☐Other: ____

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Internet ☐ Web Site ☐ Billboard ☐ Sign

☐ Friend/Family Please Name so we may thank them.________________________________ ☐ other: ___________________

When did these conditions start? __________________________________ Is this the 1st occurrence? ☐ Yes ☐ No

What aggravates these conditions? ________________________What decreases the symptoms or pain? ________________________

How did these symptoms develop? ☐ Auto Accident ☐ Work Related ☐ Other Injury

Did you report this to your auto insurance company? ☐ Yes ☐ No To your employer? ☐ Yes ☐ No

Have you had previous chiropractic care? DR. ____________________________________ Phone: ____________________________

Other doctors who treated this condition: DR. _____________________________________ Phone: ___________________________

List any prescription/ non-prescription medicine you are taking: ____

List any surgical operations you have had: ____

List any other health conditions you presently suffer from: ____

HEALTH AND WELLNESS INFORMATION (all patients)

What is your current Health & Wellness level? (Please circle: 1=Very Good – 5=Very Bad)		**What is your current interest level? (0=None – 5=High)**	
Eat healthy, balanced meals:	1 2 3 4 5	Massage therapy:	0 1 2 3 4 5
Consider calories when making food choices:	1 2 3 4 5	Nutritional support:	0 1 2 3 4 5
Physically active (outside of work):	1 2 3 4 5	Losing weight or inches:	0 1 2 3 4 5
Train with weights:	1 2 3 4 5	Free gym/workout facility:	0 1 2 3 4 5

FOR WOMEN ONLY:
Are you pregnant: ☐ Yes ☐ No ☐ Unsure If yes, when is your due date? _______________________
If you are not pregnant: What was the date of your last menstrual period? ____
If there is any possibility of pregnancy, you must inform your doctor prior to any x-rays being taken. If there is no possibility of pregnancy, please sign and date below certifying that you are not pregnant.

I hereby certify that I am not pregnant: *Signed:* ____ *Date:* ___________________

Initial________

DOCTOR'S LIEN (if this is the result of a car accident or personal injury)

All patients with a no-fault, personal injury, or worker's compensation case, please read the lien and sign below.
I hereby give a lien to American Health Centers on any settlement, claim, judgment, or verdict as a result of the accident which occurred on ___/___/___, and authorize and direct you, the insurance company, to pay directly to said office such sums from settlements, judgments, or verdicts as may be necessary to protect such doctor(s) adequately. I fully understand that I am directly and fully responsible to American Health Centers for all bills submitted by said office for services rendered to me and that this agreement is made solely for said office's additional protection and in consideration for awaiting payment. I further understand that such payment is not contingent on any settlement claim, judgment, or verdict by which I may eventually recover said fee. I hereby also grant American Health Centers limited power of attorney for the express purpose of endorsing drafts or checks received by American Health Centers which are meant as payment for services rendered to me in that office.

PRIVACY POLICY

I, ____, have been presented with a copy of American Health Centers **Privacy Policy**, detailing how my medical information may be used and disclosed as permitted under federal and state law. I have read and understood the contents of the policy. Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

PATIENT CONSENT

CONSENT FOR TREATMENT:
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).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to American Health Centers to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning your local office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

Initial________

ASSIGNMENT OF BENEFITS (all patients)

I hereby authorize the insurance company reimbursement to be paid by check, made out and mailed directly to **American Health Centers (at address noted on the bill)** the medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said service charges over and above my insurance payment. If my current policy permits payment to be mailed to my attorney only, I hereby authorize you to list **American Health Centers** as the payee on any check issued for services rendered by **American Health Centers**. I hereby also grant **American Health Centers** limited power of attorney for the express purpose of endorsing drafts or checks received by **American Health Centers** which are meant as payment for services rendered to me in that office, and apply to such funds against my outstanding account(s) in that office.

This is a direct assignment of my rights for this policy. A photocopy of this document shall be considered as effective and valid as the original.

AUTHORIZATIONS

Please read the following statements carefully:

1. Authorization to Release Medical Information
I hereby authorize the release of medical information pertinent to my case to the insurance company or to the attorney involved in my case. I further authorize the release of my medical records and reports to American Health Centers.

2. Managed Care Insured's
As a patient insured by a managed care organization, I agree to pay for those services rendered that may not be covered services in my payer contract; or for those services the MCO may deem not medically necessary, able, willing, or incapable of paying; or not rendered at a care level as determined by the MCO utilization control process.

3. Financial Responsibility
I understand that I am fully responsible to American Health Centers for all charges I incur in this office, including deductibles, co pays, co insurance and all charges not covered by my insurance.

If you have any questions, please feel free to ask.

I certify that all the information contained in this booklet is complete and true to the best of my knowledge.

Signature of patient: ____ **Date:** __________________________

Patient name (please print): ____

Witness____

Other than patient, print Name and relationship ____

Initial________