

WELCOME TO GODIN & HAUSMANN CHIROPRACTIC

PATIENT INFORMATION:

Name _____ Date of Birth _____
Home Address _____ Apt # _____
City _____ State _____ Zip Code _____
Home Phone () _____ Work Phone () _____ Cell Phone () _____
Social Security Number _____ Male _____ Female _____
Marital Status ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated
Employer _____ Occupation _____
Employer's Address _____

INSURANCE INFORMATION: Please provide this information regarding the primary policy holder i.e. spouse, guardian, etc. If you are the primary policy holder, you may leave this section blank. **PLEASE PRESENT YOUR CARD TO FRONT DESK FOR COPING.**

Name _____ Date of Birth _____
Home Address _____
Social Security Number _____ Spouse _____ Parent/Guardian _____
Home Phone () _____ Work Phone () _____

EMERGENCY CONTACT:

Name _____
Home Phone () _____ Work Phone () _____ Other Phone () _____
Relationship to Patient: _____

AUTOMOBILE ACCIDENT: Please provide this information if your visit is a result of an auto accident

Date of Accident _____ Insured's Name _____
Insurance Company _____ Claim # _____
Claim Adjuster's Name _____ Phone # _____
Attorney's Name _____ Phone # _____

WORK INJURY: Please provide this information if your visit pertains to injury suffered while at work

Date of Injury _____ Was injury reported? Yes / No Claim # _____
Employer Contact Person _____ Phone # _____
Insurance Company _____

Who may we thank for referring you to our office? _____

ACCEPTANCE AS A PATIENT: I understand that the doctors of Godin & Hausmann Chiropractic, PC have the right to refuse to accept me as a patient at any time before the treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are a part of the process of information gathering so the doctor can determine whether to accept me as a patient.

Signature _____ **Date** _____

AUTHORIZATION: Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by my insurance. I authorize Godin & Hausmann Chiropractic, PC to release any information regarding my treatment to my insurance company in an effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date** _____

Name _____ Date _____

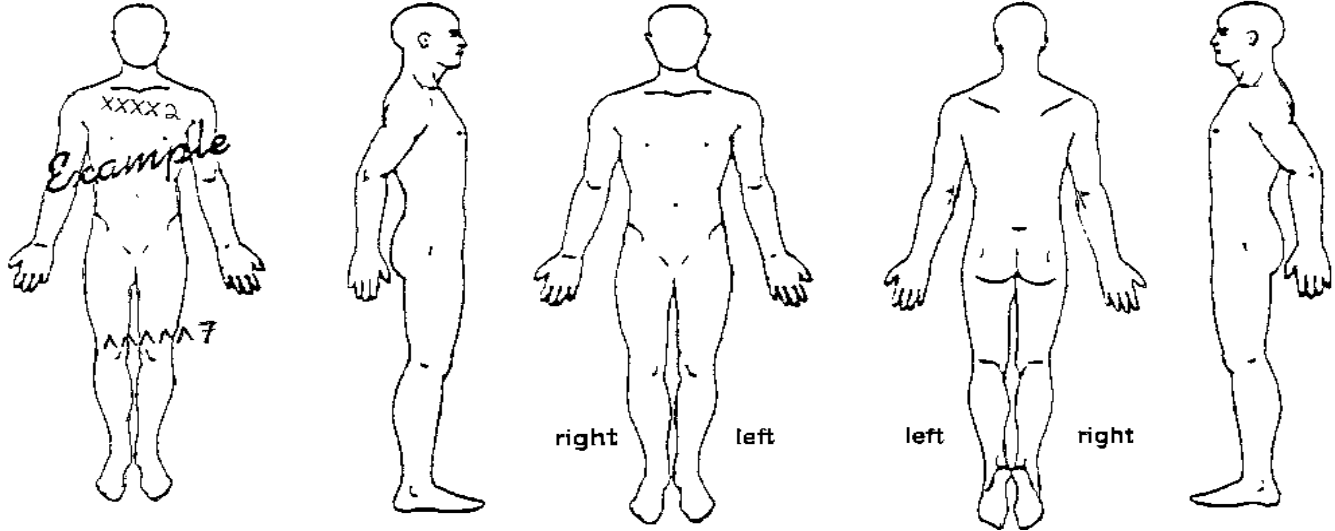
CURRENT COMPLAINT

Please make a vertical mark on the line below that best defines the intensity of your symptoms.

No Pain Unbearable Pain

Indicate where you are experiencing pain and other symptoms – please use the symbols to describe your pain.

Numbness: ----- Pins & Needles: oooooo Burning: ^^^^^^ Aching: XXXXX Stabbing: //



HEALTH HISTORY:

Who is your primary care physician and where is he/she located? _____

Are you currently under the care of the physician and/or other health professionals? (if yes, give name and date of last visit) _____

May we contact your primary care physician? Yes _____ No _____

List any surgeries or hospitalizations with their approx. date _____

List current medications and/or vitamins/supplements _____

Have you been in an auto or other accident? ___ past year ___ past 5 years ___ never Describe: _____

Do you have a history of: ___ double vision or other vision problems ___ vertigo, light-headedness
___ sudden numbness/weakness of face/arm/leg ___ speech disorders ___ difficulty swallowing ___ difficulty walking
___ vomiting or queasiness ___ loss of sensation on one side ___ involuntary rapid eye movements

Have you ever been knocked unconscious? ___ Yes ___ No Describe: _____

Do you smoke, drink coffee, soda or alcohol (if yes, indicate how much) Cigarettes ___ pack/day Coffee ___ cups/d
Soda ___ cans or oz./day Alcohol ___ drinks/week

What is your current stress level? ___ low ___ medium ___ high Reason: _____

How often do you exercise? ___ None ___ 1-2 times/week ___ 3-5 times/week ___ 6-7 times/week

Do you have a family history of: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Cardiovascular Problems/Stroke

Have you ever been under the care of a chiropractic physician? ___ Yes ___ No, this is my first experience with chiropractic.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protection your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.
4. We will not release your health information to any marketing or fund raising organizations.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The notice is posted in our office for your review. If we make a change to our privacy policies, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy our privacy notices.

Your right to limit uses or disclosures

You have a right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your written request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Name: _____

Godin & Hausmann Chiropractic, PC
90 Mendon St Bellingham, MA

Signature: _____

Date: _____

PATIENT RECORD OF DISCLOSURES

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- Home Telephone _____
 - Leave a message with detailed information
 - Leave message with call-back number only

- Written Communication
 - mail to home address
 - Email _____

- Work Telephone _____
 - Leave message with detailed information
 - Leave message with call-back number only

- Other _____

Patient or Guardian's Signature

Date

Patient's Printed Name

Birthdate