

WELCOME TO GODIN & HAUSMANN CHIROPRACTIC

PATIENT INFORMATION:

Name _____ Date of Birth _____
Home Address _____ Apt # _____
City _____ State _____ Zip Code _____
Preferred Phone Number () _____ Is it ok to leave a message? Yes No
Secondary Phone Number () _____ Is it ok to leave a message? Yes No
E-mail address: _____ May we e-mail you our newsletter? Yes No
Male _____ Female _____ Martial Status ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated
Employer _____ Occupation _____
Emergency Contact: Name _____ Phone Number () _____
Relationship to Patient: _____
Whom may we thank for referring you to our office? _____
Name of Primary Care Physician: _____ May We Contact Them? Yes No

INSURANCE INFORMATION: IF INSURED, PLEASE PROVIDE COPY OF HEALTH INSURANCE INFORMATION. IF THIS INJURY IS DUE TO AN AUTOMOBILE ACCIDENT OR WORK INJURY, PLEASE NOTIFY THE FRONT DESK.

SYMPTOMS:

Main Complaint: _____
When did they start? _____ How did they begin? _____
How often do you notice them? ___ 76-100% of the day ___ 51-75% of the day ___ 26-50% of the day ___ 0-25% of the day
What best describes the nature of the symptoms? ___ Sharp ___ Dull Ache ___ Numb ___ Shooting ___ Burning ___ Tingling
Please rate the pain with 0 being pain-free and 10 being unbearable pain. _____/10

HEALTH HISTORY:

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 been treated by a chiropractic physician in the past? ___ Yes ___ No, this is my first experience with chiropractic.

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 _____

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: _____