Peoria Spine and Sport

New Patient Information

Name _____ ☐ Female ☐ Male Date _____

What you prefer to be called _____ Age _____ Date of birth _____

Preferred Language ☐ English ☐ Other _____ Race: ☐ White ☐ African American ☐ Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Relation _____ Phone _____

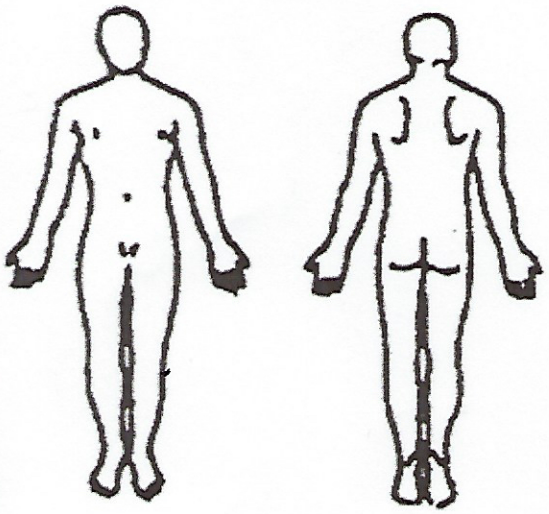
How did you hear about our office? _____

When did your condition begin? _____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician _____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications _____

_____

_____

_____

Allergies (Medicine, Food, Environment) _____

_____

Previous Surgeries _____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other _____		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health History & Assessment

Patient Name_____ **Date:** _____

Exercise: 0 1 2 3 4 5 6 7 days/ wk _____minutes. Type_____
What position do you sleep in: Side Stomach Back Other_____
How old is your mattress: _____ yrs What type: coil spring foam water air _____
What type of pillow do you sleep on: foam memory foam fiberfill feather Other_____
Do you wear: arch supports orthotics heel lifts
Do you take: blood thinners (heparin, coumadin, warfarin), birth control pills, steroids
Do you have any **family** history of: rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke

Please indicate if you have experienced any of the following conditions or symptoms:

General

- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ AIDS or HIV
- ❑ Fatigue
- ❑ Recent unexplained weight loss,
- ❑ Decreased energy
- ❑ Loss of appetite
- ❑ Night sweats
- ❑ Fever or chills
- ❑ Recurrent infections
- ❑ Fluoroquinolone antibiotic use
- ❑ Skin ulcers or rashes
- ❑ Excessive thirst

Neuromusculoskeletal

- ❑ Stroke
- ❑ Paralysis
- ❑ Seizures
- ❑ Mental disorders
- ❑ Fractures
- ❑ Dislocations
- ❑ Orthopedic problems
- ❑ Arthritis
- ❑ Rheumatoid arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Change in vision, smell, hearing or taste
- ❑ Light headedness
- ❑ Dizziness/vertigo
- ❑ Loss of consciousness
- ❑ Difficulty speaking or swallowing
- ❑ Headaches
- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Change in mood or behavior

Cardiovascular

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Irregular heart beat
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ TIA
- ❑ Peripheral vascular disease
- ❑ Blood clotting or bleeding disorder
- ❑ Anemia
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Nose bleeds
- ❑ Swollen ankles
- ❑ Redness or swelling of a limb,
- ❑ Unusual bruising
- ❑ Bleeding gums
- ❑ Swollen lymph nodes

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ COPD
- ❑ Cough or change in cough
- ❑ Blood in sputum
- ❑ Wheezing
- ❑ Difficulty breathing

Digestive

- ❑ Liver disease
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Gall stones
- ❑ Appendicitis
- ❑ Pancreatitis
- ❑ Reflux disease
- ❑ Stomach pain
- ❑ Pain or difficulty swallowing,
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloating
- ❑ Excessive gas or belching
- ❑ Blood in stool
- ❑ Black stools

Genitourinary

- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Prostate enlargement
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Increased frequency of urination
- ❑ Difficulty with urination
- ❑ Loss of bladder or bowel control
- ❑ Change in menstrual bleeding

____ Initial here if none of the listed symptoms or conditions apply to you.
I have personally read and completed this form. Signature _____

Health Insurance

Policyholder Name _____ Date of Birth _____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes ☐ No ☐ Have you reported it? Yes ☐ No ☐

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to Automobile Accident? Yes ☐ No ☐ Date of accident _____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Benjamin Deig and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. In order to ensure that all of my healthcare providers function as a team, I hereby grant the providers and clinical staff of P.S&S to communicate with and relay any information about my condition to my other healthcare providers. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from P.S&S for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct P.S&S , it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____

Peoria Spine and Sport

PRIVACY POLICY INFORMATION

This document describes how Chiropractic and medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.

In the course of your care as a patient at Peoria Spine and Sport, we may use and disclose personal and health related information about you in the following ways:

-personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnostic assessment or treatment

-health and billing records may be disclosed to another party such as an insurance carrier or your employer if they are responsible for payment of your services

-personal information, health records and billing records may be disclosed to an outside collection agency if needed in an effort to collect payment on overdue unpaid accounts with an outstanding balance

Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine. You have the right to inspect or obtain a copy of the information that we will use for these purposes. You have the right to refuse to provide us with authorization to contact you regarding these matters. Refusal to provide authorization will not affect the care provided to you or the reimbursement avenues associated with your care.

If required, statements regarding the outstanding remaining balance of your account may be mailed to the address you provided on your intake paperwork.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

-if we are providing health care services based on orders from another health care provider

-if we provide health care services in an emergency

-if there are substantial barriers to communicating with you, but it is in our professional judgment that we believe you intend for us to provide care

-if we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than outlined above will only be made upon your written authorization.

If you would like additional information regarding our privacy practices, would like to make a complaint regarding our privacy practices or have additional questions, please contact Dr. Benjamin Deig.

You have the right to inspect and/or have a copy of your health information for seven years from the date that the record was created or as long as the information remains in our files. Requests must be provided to our office in writing,

Peoria Spine and Sport

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, HAVE RECEIVED, REVIEWED AND UNDERSTAND THE PRIVACY POLICIES OF PEORIA SPINE AND SPORT.

_____
Signature

_____
Print Name

_____
Date

(Office use only)

We attempted to obtain written acknowledgement of receipt of our Privacy Policy Information, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledge
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

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