

## Patient Information

Legal First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street: (NO PO BOXES) \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: S M W D Spouse: \_\_\_\_\_

Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Indian \_\_\_\_\_ Japanese \_\_\_\_\_ Chinese \_\_\_\_\_ Korean \_\_\_\_\_ French \_\_\_\_\_  
German \_\_\_\_\_ Russian \_\_\_\_\_ Other \_\_\_\_\_

Race: White \_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_ Asian \_\_\_\_\_  
Native Hawaiian/Other Pacific Islander \_\_\_\_\_ Black or African American \_\_\_\_\_  
Hispanic or Latino \_\_\_\_\_ Decline to Answer \_\_\_\_\_

Ethnicity: Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_ Decline to Answer \_\_\_\_\_

Birthdate: \_\_\_\_\_ Email home: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Contact Preference: Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_ Cell \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_ Postal Mail \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Insurance Information

*We will make a copy of your insurance card(s). However, please complete the following information.*

Insurance company name \_\_\_\_\_

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Primary policy Holder's Name (if different than patient)

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

# Assignment & Release

## **Insurance Information & Assignment**

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information I provided is incomplete or inaccurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. I understand my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary. I also understand that a \$25 fee will be imposed upon me for both (1) returned checks, and (2) missed appointments without 24 hours notice of cancellation.

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed directly to: David Meltzer, DC, 1834 Soscol Ave. - Suite C, Napa, CA 94559 the professional expense benefits allowable and otherwise payable to me under this insurance policy, as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This payment will not exceed my indebtedness to the above-referenced assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient/Parent/Guardian: \_\_\_\_\_

Printed name of Patient/Parent/Guardian: \_\_\_\_\_ Date signed: \_\_\_\_\_

## **Consent of Professional Services and Release of Information**

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to 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 service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature of Patient/Parent/Guardian: \_\_\_\_\_

Printed name of Patient/Parent/Guardian: \_\_\_\_\_ Date signed: \_\_\_\_\_

## **Permission to Treat Minor (if applicable)**

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary to my children.

Print Name of minor: \_\_\_\_\_

Relationship to minor (circle one):     Parent   Legal guardian

Printed Name of Parent or Legal Guardian \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_ Date signed: \_\_\_\_\_

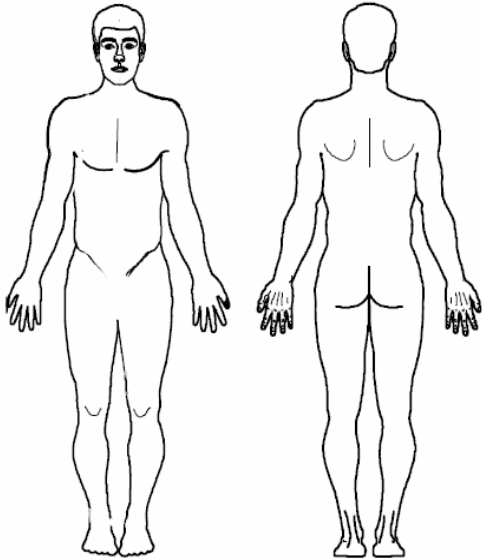
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient History

Give a brief detailed description of the problem(s) you are currently experiencing: (Indicate the pain level of each symptom on a scale of 1 to 10). [0=no pain and 10=unbearable pain]

\_\_\_\_\_  
\_\_\_\_\_

PLEASE INDICATE ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:



Date problem began? \_\_\_\_\_ Quality of pain: achy burning dull sharp stiff throbbing

How often are your symptoms present (circle one)? 0-25% 26-50% 51-75% 76-100%

Is it getting worse? Yes No \_\_\_\_\_

What seemed to be the initial cause: \_\_\_\_\_

What makes it feel better? \_\_\_\_\_ Worse? \_\_\_\_\_

Does it get better, worse, or stay the same as the day goes on? \_\_\_\_\_

Have you had x-rays, MRI, CT scan for the above-mentioned complaint(s)? (date of study and what areas filmed) \_\_\_\_\_

Are you seeing anyone else for other problems or health conditions? (circle one) Yes No

Please list the problem(s), date problem(s) began, and Provider(s) treating you for the condition(s):

\_\_\_\_\_  
\_\_\_\_\_

Have you ever seen a chiropractor before? Y N If so, when was your last visit? \_\_\_\_\_

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	—	—	_____
...been diagnosed with Diabetes	—	—	_____

Type I \_\_\_\_\_ or Type II \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Circle all that apply to you:

- |  |   |
|--|---|
| Recent fever                                     | Prostate problems   |
| High blood pressure                              | Menstrual problems  |
| Stroke (date)                                    | Urinary problems  |
| Corticosteroid Use (cortisone, prednisone, etc.) | Currently pregnant, # weeks _____   |
| Taking birth control pills                       | Abnormal weight <input type="checkbox"/> gain <input type="checkbox"/> loss |
| Dizziness/Fainting                               | Marked morning pain/stiffness   |
| Numbness in groin/buttocks                       | Pain unrelieved by position or rest   |
| Cancer/Tumor (explain) _____                     | Pain at night   |
| _____  | Visual disturbances   |
| Osteoporosis                                     | Epilepsy/seizures   |
| Other health problems (explain) _____            | Surgeries _____   |
| _____  | _____   |
| _____  | _____   |

Medications

What medications are you currently taking? Include vitamins, herbs, mineral. List: Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Prescribed by. Please be as specific as possible

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke?

- Never    Former Smoker    Current/Every Day Smoker    Current Some Day Smoker

Do you have allergies?    Food    Environmental    Medication

List Type of Allergy and Reaction

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family history (circle all that apply)

- Cancer    Diabetes    High blood pressure    Heart problems/stroke    Rheumatoid arthritis

Vitals (for office use only- completed by staff)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

## Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular, you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The possibilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care, as well as to the care of my children.

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Patient Signature

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Patient Name (Please Print)

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Date

## Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

### Uses and Disclosures

Your protected health information is accessed and used for healthcare related purposes only.

Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.

Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

### Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances, Medical emergencies; in situations required by law; individuals involved in your care; when requested by public health agency; when requested by a law enforcement agency.

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

### Patient Rights

You have the right to request in writing to inspect and/or receive a copy of your health information. \*

You have the right to request an alternate means or location to receive communications regarding your health information. \*

You have the right to request in writing to amend, correct, or delete any recorded health information within our possession. \*

You have the right to request in writing to restrict some of the uses and disclosures of your health information. \*

You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. \*

*\* Conditions and limitations may apply; obtain additional information from the office.*

**Changes To This Notice:** We reserve the right to change privacy practices and the condition of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be sent to you.

I, (Print Name) \_\_\_\_\_,  
acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### If the patient is a minor:

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian Printed Name \_\_\_\_\_

Patient's (minor) printed name \_\_\_\_\_

### If the patient is not a minor, but under the care of a relative, friend, or caregiver:

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Patient's printed name \_\_\_\_\_