CHIROPRACTIC

New Patient Paperwork

Please write legibly and fill out to the best of your ability.

Full Name: _____ **Birth Date:** _____ **Male / Female**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone number: _____ **Email:** _____

Social Security Number: _____

Occupation/Employer: _____

Marital Status: Single Married Widowed Divorced

How did you hear about us? Social Media Search Engine Drive By Advertisement Event

Referral: _____ Other: _____

Which doctor would you like to see today? Dr. Joren Whitley Dr. Lindsee Zehe No Preference

Have you seen a chiropractor before? Yes / No **If so, when?** _____

Were you recently in a motor vehicle accident? Yes / No **If YES, when?** _____

I hereby authorize the doctor to examine me and to perform any necessary diagnostic procedures to fully evaluate my condition for the presence of vertebral subluxations and if necessary render Chiropractic services to me. By signing below, I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee as to the results that may be obtained. I also understand that I am responsible for all charges.

Print Name: _____ **Date:** _____

Patient/Guardian Signature: _____

What is the number one thing bothering you today?_____

When did your pain begin? _____ **Pain Level:** 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better or Getting Worse **Is your condition:** On & Off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull

Radiating: Left/Right Base of Skull Shoulder Arm Hand

What makes it better? Ice Heat Rest Movement

What makes it worse? Sitting Standing Walking Lying Down Sleep Overuse

Does it interfere with: Work Sleep Daily Routine Recreation

Put an "X" next to all of the conditions you have suffered from in the past 6 months:

___Depression ___High Blood Pressure ___ High Cholesterol

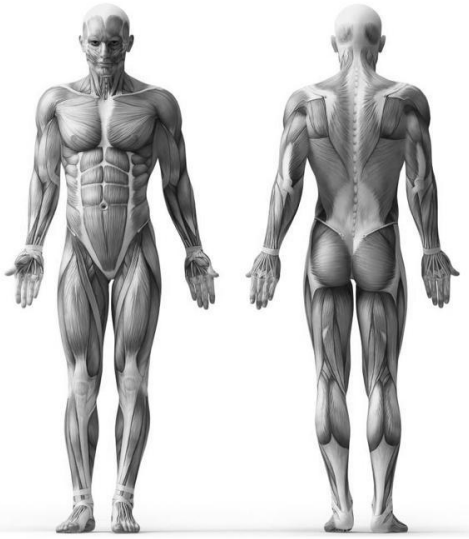
___Thyroid Problems ___Headaches/Migraines ___Sinus Issues

___Heart Condition ___Breathing Problems ___Digestive Problems

___Bowel Problems ___Urinary Problems ___Liver Problems

Other: _____

"X" Your Problem Areas Below:



Have you seen anyone else for this condition? (circle) Y / N
If so, who: _____

Were you involved in an accident? Auto / Fall / Work / Other: _____

List of medications you are currently taking: _____

List of past Surgeries & Dates:_____

Do you have any other physical complaints? _____

Habits: Cigarettes – (#/day) _____ Alcohol – (amount/day) _____ Rec. Drugs – (list)_____

Patient Signature: _____ **Date:** _____

Consent to Treat

Please Initial next to ALL agreements.

_____ **Consent to Examination and Treatment:** I give the doctors and staff of Oklahoma Chiropractic permission to perform all examinations, x-rays, and treatments deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or doctor.

_____**HIPPA:** A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states as our patient your privacy is protected. By signing you are stating that you understand that Oklahoma Chiropractic may use or disclose your protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

_____ **Pregnancy Waiver (X-rays):** By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time for the purpose of taking X-rays.

_____ **Self Pay**: I understand that in the absence of health insurance coverage or in the instance of a denial of coverage by a third party provider that I will be held responsible for the services that I receive from Oklahoma Chiropractic office.

_____ **Consent to Bill Insurance**: I consent, if I am using a third party for payment of my service (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc.) to allow Oklahoma Chiropractic (Dr. Joren Whitley) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor.

_____ **Video Material:** I give the doctors and staff at Oklahoma Chiropractic permission to video record/phonograph office visits and procedures for educational and/or office use.

Patient Name: _____ **Date:** _____

Patient Signature: _____