WELCOME

PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

City ____________________

State ____________ Zip ____________

E-mail ____________________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

PHONE NUMBERS

Home Phone (______) ____________________

Cell Phone (______) ____________________

Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________________

Home Phone (______) ____________________

Work Phone (______) ____________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date ____________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____

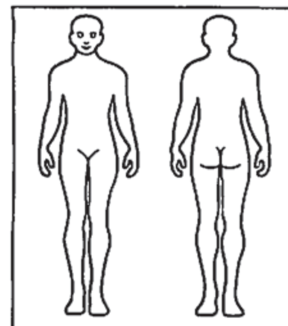
PATIENT CONDITION

Reason for Visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

Date of Last: Physical Exam __________ Spinal X-Ray __________ Blood Test __________

Spinal Exam __________ Chest X-Ray __________ Urine Test __________

Dental X-Ray __________ MRI, CT-Scan, Bone Scan __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐	☐	Chicken Pox	☐	☐	Liver Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Alcoholism	☐	☐	Diabetes	☐	☐	Measles	☐	☐	Rheumatic Fever	☐	☐
Allergy Shots	☐	☐	Emphysema	☐	☐	Migraine Headaches	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Miscarriage	☐	☐	Stroke	☐	☐
Anorexia	☐	☐	Fractures	☐	☐	Mononucleosis	☐	☐	Suicide Attempt	☐	☐
Appendicitis	☐	☐	Glaucoma	☐	☐	Multiple Sclerosis	☐	☐	Thyroid Problems	☐	☐
Arthritis	☐	☐	Goiter	☐	☐	Mumps	☐	☐	Tonsillitis	☐	☐
Asthma	☐	☐	Gonorrhea	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Bleeding Disorders	☐	☐	Gout	☐	☐	Pacemaker	☐	☐	Tumors, Growths	☐	☐
Breast Lump	☐	☐	Heart Disease	☐	☐	Parkinson's Disease	☐	☐	Typhoid Fever	☐	☐
Bronchitis	☐	☐	Hepatitis	☐	☐	Pinched Nerve	☐	☐	Ulcers	☐	☐
Bulimia	☐	☐	Hernia	☐	☐	Pneumonia	☐	☐	Vaginal Infections	☐	☐
Cancer	☐	☐	Herniated Disk	☐	☐	Polio	☐	☐	Venereal Disease	☐	☐
Cataracts	☐	☐	Herpes	☐	☐	Prostate Problem	☐	☐	Whooping Cough	☐	☐
			High Cholesterol	☐	☐	Prosthesis	☐	☐	Other ______		
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Psychiatric Care	☐	☐	______		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day __________
☐ Alcohol Drinks/Week __________
☐ Coffee/Caffeine Drinks Cups/Day __________
☐ High Stress Level Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date __________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name __________		
Pharmacy Phone (_____) __________		

adjust
CHIROPRACTIC

9041 Garland Rd.
Dallas, Tx 75218
p:214.922.8844
f:214.3685656

I hereby
authorize:____
(Name of Doctor, Medical Facility, Lab)

To disclose to **adjust Chiropractic clinic; 9041 Garland Rd.; Dallas, TX 75218; phone: 214-922-8844; fax 214-368-5656, John Botefuhr DC**

Release of medical records and medical information pertaining to:

Name:_______________________ Date of birth:_______________________

Address:_______________________ Telephone number:_________________

Rendered during Dates of services:_________________________________

Check the box to specify which type of records and information is to be disclosed:

□ Medical information

□ Radiology x-rays, MRIs, CT's

□ Surgeries/operative notes

□ Therapy/program notes

□ Other (specify):___________________________

□ Check if Worker's Compensation claim:

If this is a workers compensation claim The following information may be helpful to HCPs. HIPAA permits health care providers who treat injured workers and are "covered entities" to disclose protected health information (PHI) to workers' compensation insurers, State administrators, employers or other persons or entities involved in the workers' compensation system without the individual's authorization:

- As authorized and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work related injuries or illness without regard to fault. 45 C.F.R. §164.512(l).
- To the extent state or other law requires disclosure. The disclosure must comply with and be limited to what the law requires. 45 C.F.R. §164.512(a).
- For purposes of obtaining payment for any health care provided to an injured or ill worker. 45 C.F.R. §164.502(a)(1)(ii).

Texas state law specifically authorizes a HCP to release PHI for the purposes of billing. Section 408.025 (d) of the Texas Workers' Compensation Act states, "*A health care provider may disclose to the insurance carrier of an affected employer records relating to the diagnosis or treatment of the injured worker without the authorization of the injured worker to determine the amount of payment or the entitlement to payment.*" DWC encourages HCPs to provide the necessary PHI information with their bills to prevent incorrect coding and billing, improper reimbursement, and unnecessary disputes. For more information concerning HIPAA and the disclosure of workers' compensation information, please see Advisory 2003 05, Clarification on the HIPAA Privacy Rule and Disclosures to the DWC, effective May 6, 2003.

Signed:_______________________ Date:_______________________

Work Accident Chiropractic Clinic
9041 Garland Rd
Dallas, TX 75218
(214) 922-8844
Fax (214) 368-5656
office@adjustchiropracticdallas.com

NEW PATIENT DOCTOR INFORMATION FORM

NAME (PRINT):______________________________ DATE:__________

SIGNATURE:____________________________ DATE OF INJURY:_______

HAVE YOU SEEN OTHER DOCTORS FOR THIS ACCIDENT/CONDITION?

NO - THIS IS THE FIRST AND ONLY TIME I HAVE SOUGHT TREATMENT FOR THIS DATE OF INJURY.

YES - EMERGENCY RM. DR.____________________________DATE_________
HOSPITAL____
PHONE #________________________ FAX #______________________

COMPANY DOCTOR______________________# OF WEEKS?_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

TREATING DOCTOR______________________# OF WEEKS?_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

MRI/CT SCAN/X-RAY DR.________________________DATE_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

PHYSICAL THERAPY/REHAB DR.______________ # OF WKS_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

PAIN MANAGEMENT DR.____________________ # OF WKS_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

SURGEON/SURGERY__________________________DATE_________
FACILITY/CLINIC NAME____
PHONE #________________________ FAX #______________________

adjust
CHIROPRACTIC

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CONSENT TO TREAT

INFORMED CONSENT and PROTECTED HEALTH INFO NOTICE AGREEMENT

Physicians, Chiropractors, and Physical Therapists may advise patients with spinal problems, such as yours, that in recent years there have been alleged incidents of injury to the vertebral artery during the course of treatment. Symptoms reported have included nausea, dizziness, and lightheadedness, which usually have been temporary in nature. According to the latest studies, there is a dispute as to whether this is possible unless atherosclerosis is present. The chance of an occurrence is estimated at 1 in one million. In comparison, the chance of a serious outcome for playing football is approximately 1 in twenty-five thousand; for taking aspirin is 1 in ten thousand; for taking birth control pills is 1 in five thousand; and about the same for driving a car 1 mile. Tests, with or without x-rays, may be performed during your examination to minimize your risk.

On occasion, tenderness and soreness may occur following an adjustment, similar to what may be felt after working out in a gym or after aerobics. If your pain persists or increases, you should report this to your doctor as soon as possible. If you are accepted as a patient, chiropractic and/or acupuncture is considered to be one of the safest and most effective forms of therapy for your type of problem.

I hereby authorize Dr. John Botefuhr DC, herein "the doctor", to examine and treat my condition, as he deems appropriate through the use of any combination of radiographs, manipulation (inclusive of my spine and extremities), therapy, rehabilitative exercises, spinal decompression, cold laser, and/or acupuncture. I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocation, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, or for any medical diagnosis.

I have read and understand the above statements and conditions, and hereby request and consent to the performance of chiropractic adjustments/manipulation and/or other supportive procedures including various modes of therapy, ultrasound diathermy, cold laser and EMS on me (or the patient named below for whom I am legally responsible), by any of the doctors or therapists at this clinic, and/or any other doctors or therapists who, now or in the future, may treat me while at this clinic, or serve as relief, support, or back-up for the doctors or therapists at this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also agree to keep Dr. Botefuhr informed of any future changes in my health that may be unknown to me at this time.

Patient Signature_______________________ Date _______________

Witness Signature ______________________________ Date____________