ALLIANCE CHIROPRACTIC & MASSAGE

TRISTA M. DELUCA, DC 610 East Broad Street Souderton, PA 18964 **215-723-7500**

PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____

ADDRESS_____HOME PHONE_____

_____ ZIP_____WORK PHONE_____

E-MAIL ADDRESS _____ CELL PHONE_____

◯Married ◯Single ◯Widowed ◯Divorced ◯Separated PARTNER/SPOUSE_____

EMERGENCY CONTACT_____ PHONE (not home)_____

CURRENT HEALTH PROBLEMS

Please list below the reasons for today's visit in the order of importance.

1. _____ How long?_____

2._____ How long?_____

3._____ How long?_____

Is ANY condition related to an accident? Yes___ No___ / Auto___ Other___ / Date of Accident_____

What Doctors have you seen for your problem(s)? DR._____ Office_____

DR._____ Office_____

Family History related to condition? Yes____ No____ Have you ever been hospitalized? Yes____ No____

List any surgeries 1._____ 2._____ 3._____

INSURANCE INFORMATION

Does your health insurance require a referral to see a specialist? Yes____ No____

Health Insurance _____ Subscriber_____ Birth Date_____

I authorize direct payment of medical benefits to this office and I am responsible for my co-pay at time of service or any balance not covered by my insurance _____

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

I acknowledge having read and/or requested a copy of the Notice of Privacy Practices of this office.
I acknowledge the information given is true to the best of my knowledge.
I allow treatment and my medical information recorded for documentation purposes.
I authorize Alliance Chiropractic to release medical or incident information necessary for care or benefits.
A photocopy of these assignments is as valid as the original.
24 hr notice is expected to cancel an appointment or a $**20.00** fee may be charged.
I understand that if my check is returned for insufficient funds, or my account has to be turned over to a collection agency, I will incur a $**25.00** plus all fees for this processing.

_____ _____

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

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HEALTH HISTORY

Name _____ Age ____ Date Last Physical_____

Are you presently under a Physicians care? Yes__ No__ Reason_____

SYMPTOMS (Check symptoms you currently have or have had in the past 3 years)

CONSTITUTIONAL
__Chills
__ Fainting
__Fever
__Loss of Sleep
__Loss of Weight
__Nervousness
__Sweats

EARS, NOSE, THROAT, MOUTH
__Bleeding gums
__Difficulty swallowing
__Earache
__Hoarseness
__Loss of hearing
__Nosebleeds
__Ringing in ears
__Sinus problems

EYES
__Blurred vision
__Crossed eyes
__Double vision
__Redness
__Visual flashes/halos
__Watering

OCCUPATIONAL CONCERNS
__Hazardous Substances
__Long distance Driving
__Desk Work
__Lifting
__Repetitive work
__Stress

Occupation_____

SKIN
__Bruise easily
__Change in moles
__Hives
__Itching
__Jaundice
__Rash
__Scars
__Sore won't heal

CARDIOVASCULAR
__Chest pain
__Irregular heart beat
__High blood pressure
__Low blood pressure
__Poor circulation
__Rapid heart beat
__Swelling of ankles
__Varicose veins

NEUROLOGICAL
__Dizziness
__Forgetfulness
__Headaches
__Loss of consciousness
__Numbness
__Shaking

GENITO-URINARY
__Blood in urine
__Frequent urination
__Lack of bladder control
__Painful urination
__Urgency

GU: MALES
__Discharge
__Testicular mass
__Testicular tenderness

GU: FEMALES
__Bleeding between periods
__Breast lump
__Extreme menstrual periods
__Hot flashes
__Nipple discharge
__Painful intercourse
__Vaginal discharge

Date of last menstrual period
_____

Are you pregnant? __yes __no
Number of children_____
Date of last mammogram_____

ENDOCRINE
__Cold intolerance
__Goiter
__Growth changes

RESPIRATORY
__Asthma
__Coughing
__Difficulty breathing
__Persistent cough
__Wheezing

HEMATOLOGIC
__Bleeding disorders

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders
__Fracture_____

GASTROINTESTINAL
__Appetite poor
__Bloating
__Bowel habit changes
__Constipation
__Diarrhea
__Excessive hunger
__Excessive thirst
__Gas
__Heartburn
__Hemorrhoids
__Indigestion
__Nausea
__Rectal bleeding
__Stomach pain
__Vomiting
__Vomiting blood

HEALTH HABITS
__Caffeine Daily use _____
__Tobacco Daily use _____
__Alcohol Daily use _____
__Drugs Daily use _____
__Exercise Daily use _____

OTHER _____
_____

CONDITIONS (Check conditions you have had in the past)

__Abnormal Pap
__AIDS
__Alcoholism
__Anemia
__Angina
__Anorexia
__Arthritis
__Asthma
__Bleeding disorders
__Breast lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chem. Dependency
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gout
__Heart disease
__Headaches
__Hernia
__Herpes
__Hepatitis
__HIV positive
__High blood pressure
__High cholesterol
__Irregular periods
__Kidney disease
__Liver disease
__Migraines
__ Miscarriage
__Multiple sclerosis
__Pacemaker
__Pneumonia
__Polio
__Prostatitis
__Psychiatric care
__Rheumatic fever
__Sexual trans dis.
__Stroke
__Suicide attempt
__Thyroid problems
__Tonsillitis
__Tuberculosis
__Ulcers
__Urethral dis/inf
__Vaginal infections
Other_____

ALLERGIES (List all types of allergies)

1._____ 2._____

3._____ 4._____

VITAMINS (List what you are currently taking including dosage)

1._____ 2._____

3._____ 4._____

MEDICATIONS (List medications currently taking including dosage) ***Check here if you have a medicine list to be copied*** __

1._____ 2._____

3._____ 4._____

I certify the information given is correct to the best of my knowledge. I will not hold my doctor or his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Name_____ **Date** _____

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Print Name_____ **Date of Birth**_____

I authorize any medical, osteopathic, chiropractic physician, medical practitioner, healthcare provider, rehabilitation facility, hospital, clinic or any other healthcare facility to disclose information from medical and healthcare records.

I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, diagnostic tests, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans, and other information with ALLIANCE CHIROPRACTIC doctors, associates, and staff. I understand Alliance Chiropractic may disclose medical or other information obtained by this authorization to physicians, other medical or healthcare providers or other professions for their professional opinion.

I understand that I may refuse to authorize disclosure of all or some of the requested information. This authorization may be revoked at any time in writing, dated, and signed. This specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act. I understand this authorization was developed pursuant to the Heath Insurance Portability and Accountability Act of 1996. (HIPAA)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received or read a copy of this office's Privacy Practices and sign this document as a voluntary act.

Alliance Chiropractic strives to keep your Health Information Private. We understand your medical information is personal and we are committed to protecting it, however, in our daily procedures, the following may possibly compromise your privacy:

Phone calls; patients' charts and cards in use; x-rays in use, discussions amongst Doctors, Patients, Staff or Authorized visitors; appointment books; mailings; receipt books; computers; bulletin boards.

As a patient in our practice, we may need to communicate with you. Please list any type of communication you prefer us ***not*** to use. _____.

It is understood that person(s) having access to the same devices may intercept the communication

I understand I have the right to revoke this authorization by writing to Alliance Chiropractic.
I understand I have the right to refuse to sign this authorization.

_____ _____

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

TREATMENT OF A MINOR

I authorize ALLIANCE CHIROPRACTIC to treat my child, _____in my absence.
This authorization will stay in effect unless I notify Alliance Chiropractic in writing.

_____ _____

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because_____