WELCOME

PATIENT INFORMATION

Date_______________

Patient_______________

Address_______________

____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_______________

Occupation_______________

Employer_______________

Employer Address_______________

Employer Phone_______________

Spouse's Name_______________

Birthdate_______________ SS#_______________

Occupation_______________

Spouse's Employer_______________

Whom may we thank for referring you?_______________

*Email address:*_______________

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, the undersigned certify that I (or my dependent) have insurance coverage with_______________ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

_______________ _______________
Relationship Date

PHONE NUMBERS

Home_______________ Work_______________ Ext_____

Best time and place to reach you_______________

IN CASE OF EMERGENCY, CONTACT:

Name_______________ Relationship_______________

Home Phone_______________

Work Phone_______________ Ext_____

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)_______________

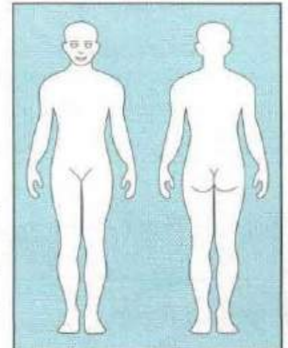
PATIENT CONDITION

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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ____________
☐ Heavy	☐ Heavy Labor	☐ 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 ____________	____________	____________

EHR Certification – Patient Information 2

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) ______________________ **Today's Date:** ____________

Date of Birth: ____________

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle all that apply)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other________

If there is an emergency, in which language would you like to receive the message?

____

What is your preferred method of contact?

Phone Number: ______________________

Home	Work	Cell

Phone Call: ☐ Text: ☐ E-Mail: ☐

If email was not your preferred method, please give your email address here:

____

Mailing Address: ____

____

____

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?

Secret Question: ____

Secret Answer: ____

OFFICE USE ONLY

Vitals: In EZnotes, complete by 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_________ **Height:** _____________ Weight: ________________

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

If you smoke, how many cigarettes do you smoke per day?____________________________

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line: Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache	**Severity:** i.e. Mild, Moderate, Severe, Fatal

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?	Hypertension (high blood pressure)?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

Timely access: In EZnotes, complete by 1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*" ☐ Completed?

Medications In EZnotes complete by 1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

Entered into EZnotes by (name): ______________ **Date & Time:** ______________ ☐ Completed?