CONFIDENTIAL NEW MEMBER INFORMATION PERSONAL INJURY

Last Name:_____________________________ First Name: ____________________MI _____Date:_________
Address:____City/State/ZIP:__________________________
Best Contact #__________________D.O.B.:___/___/____Age:___ Social Security Number:_____-_____-____
Driver's License State and #: ______________________________ Occupation: ___________________________
Employer( ) Not working or Company Name: ____
Address:____
City/State/ZIP:____ Work Phone: _________________________
Email: _______________________________________Who may we thank for referring you? _______________
Sex: M / F Single / Married / Divorced / Widowed Spouse's Name:__________________________________ _
Name and Ages of Children:____
____

If Minor, Parent or Legal Guardians Names: ____
Signature Authorizing Care of Minor: ____

AUTO INSURANCE OF THE CAR YOU WERE IN DURING THE ACCIDENT

Policy Holder Name____
Ins. Company Name________________________________ Policy #________________ Claim #_____________
Address_____________________________________ Agent___________________ Phone #________________
Has the insurance company been notified? YES NO
Make and Model of the vehicle you were in____ Year__________

DATE OF ACCIDENT (/ /)

YOUR ATTORNEY

First Name_____________________ Last Name___________________________ Phone # __________________
Address____City/State/Zip__________________________

IF YOU WERE NOT IN YOUR OWN CAR, WHAT INSURANCE DO YOU HAVE ON YOUR OWN CAR?

Policy Holder Name____
Ins. Company Name________________________________ Policy # _____________ Claim #________________
Address_____________________________________ Agent____________________ Phone #_______________

OTHER VEHICLE INSURANCE COMPANY INFORMATION

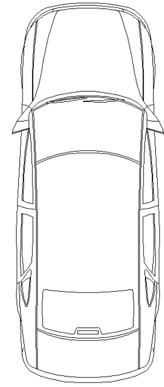
Policy Holder Name____
Ins. Company Name________________________________ Policy # _____________ Claim #________________
Address_____________________________________ Agent____________________ Phone #_______________
Make and Model of other vehicle if known ____

WORKERS COMPENSATION INFORMATION

Employer at time of accident ____
Address____City/State/Zip______________________________
Employer's Insurance Carrier____
Address____City/State/Zip_____________________________
Claim #____ Phone # _______________________________

CHIROPRACTIC first FAMILY WELLNESS CENTER

Patient Name: ____
DATE OF ACCIDENT (/   /   )



Please mark on the picture, how the vehicle was damaged in the accident:

CHECK ONE

You were: ___the driver ___front seat passenger ___rear seat passenger

Your vehicle was struck:
___in the rear ___in the right rear ___in the left rear
___in the driver's side ___in the passenger's side
___in the front ___in the left front ___in the right front
Other, explain____

Your vehicle was struck by: ___another car ___SUV/truck ___bus ___van
Your vehicle was:
___stopped at a traffic signal ___stopped at a stop sign ___making a U-turn
___stopped for a pedestrian ___stopped for traffic ___at a complete stop
___slowing down to park ___slowing down for a traffic signal ___making a left turn
___slowing down for a stop sign ___slowing down for a pedestrian ___making a right turn
___slowing down for traffic ___slowing down to turn ___moving with the flow of traffic
Other, explain ____
At that time, it was: ___daylight ___getting dark ___getting light ___nighttime
The road was: ___wet ___dry ___snow covered ___icy
Have you had any other accidents or injuries since this accident? NO YES If YES, please explain ___________
____

Your hobbies/interests/activities: ____
Do you exercise? NO YES: How often? ____________ What type? __________________________
Rate your diet: Healthy Average Poor Do you use Vitamins/Supplements: YES NO__________________
Alcohol: Never/Rare/Moderate/Daily Smoker? NO YES __#packs/day since year:_____ Past smoker? NO YES
Previous chiropractic care? YES NO If yes, Dr.'s Name: _____________________________ Last visit? ______
Other doctors you are currently seeing: ____
Current medications:____
Over the counter drugs taken in the past 3 months: ____________________________________
List all surgeries:____
List all accidents and falls: ____

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic authorized by Chiropractic First. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or 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 upon the facts then known, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care and any care in the future.
I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

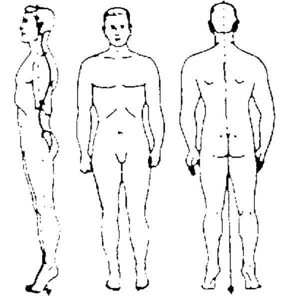
Signature:_________________________________ Witness:________________________________
Print Name:_________________________________ Date: _______________

CHIROPRACTIC first
FAMILY WELLNESS CENTER

HEALTH HISTORY FORM

Patient's Name____Date______/______/______

Section A: Current Problem Please answer the following questions regarding your **current** problem:



Please mark on the picture, where you have any problems.
Date of Onset: __________ Cause of Condition (if known)____________________
How often during the day do you experience this?
☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%
Describe the pain: ☐ sharp ☐ dull ☐ achy ☐ stiff ☐ shooting ☐ burning ☐ spasm
How severe is this problem? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme
Since the onset, is the pain? ☐ worse ☐ better ☐ same ☐ on & off
Is there anything that makes it worse? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is there anything that makes it better? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is this problem? ☐ Better or ☐ Worse ☐ AM or ☐ PM ☐ Neither
Are any systems involved? ☐ Digestive ☐ Cardiovascular ☐ Respiratory ☐ Elimination ☐ Reproductive
Does the pain cause you to? ☐ Lose sleep ☐ Be short tempered ☐ Miss work ☐ Miss play ☐ Lose focus
What has this problem kept you from enjoying? ______________________________________
Have you had a similar condition in the past? Y N If yes, explain: ____________________________
What treatment(s) have you already had for this problem?
Medication Surgery Physical Therapy Chiropractic None Other:________________
What was the outcome of this treatment?____
Any other facts about your current problem or pain: ____________________________________
____
____
Is there any chance you could be pregnant? YES NO Date of last menstrual period:____________________

Section B: Health History (Please ✓ if you have had or are currently experiencing any of the following:)

☐ Anxiety	☐ Anemia	☐ Arthritis	☐ Thyroid Problems	☐ Bowel Problems
☐ Cancer	☐ HIV/AIDS	☐ Tuberculosis	☐ High Blood Pressure	☐ Heart Trouble
☐ Diabetes	☐ Hepatitis	☐ Insomnia	☐ Venereal Disease	☐ Muscular Dystrophy
☐ Epilepsy	☐ Dizziness	☐ Convulsions	☐ Multiple Sclerosis	☐ Rheumatic Fever
☐ Neuritis	☐ Asthma	☐ Scarlet Fever	☐ Digestive Problems	☐ Sinus Trouble
☐ Allergies	☐ Backaches	☐ Numbness	☐ Frequent Colds	☐ Nervousness
☐ Stroke	☐ Depression	☐ Headaches	☐ Cold Hands/Feet	☐ Restless Sleep
☐ Ulcer	☐ Irritability	☐ Impulsivity	☐ Low Pain Threshold	☐ Fibromyalgia
☐ Hernia	☐ PMS	☐ Bruising	☐ German Measles	☐ Osteoporosis
☐ Nausea	☐ Swelling	☐ Mood Swings	☐ Chronic Fatigue Syndrome	☐ Infertility

Describe other details about YOUR Past Medical History:__________________________________
____
____

Section C: Family History (Your Blood Relatives Only)
☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Thyroid Problems ☐ Stroke ☐ Multiple Sclerosis
☐ Other: ____

NOTICE OF PRIVACY FOR:
PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Mailings for appointment reminders, birthday cards, bills and other correspondence.
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.
Please note the Doctors of Chiropractic First utilize an open area for the delivery of care and it is understood that if a patient/client needs to speak on a matter of personal privacy it is solely the responsibility of the patient to request a private area for the discussion to take place.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr. Andrew Williamson
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected by health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

____________________________	______________________________________	_____________
Name of Patient (print)	Signature of Patient/Legal Representative	Date

CHIROPRACTIC first
FAMILY WELLNESS CENTER

AUTHORIZATION AND ASSIGNMENT

You are hereby authorized to furnish my attorney(s) any and all medical information, bills and records which they may request in reference to all illnesses and injuries suffered by me, my wife, my husband, or children, including, but not limited to, the injuries sustained on the date of the accident identified below.

I further irrevocably assign to you and authorize and direct my attorney(s) to pay from the proceeds of any settlement, judgment or insurance policy, all reasonable fees for health care services, equipment, supplies, preparation of reports, and testimony provided by you as a result of the injury or condition sustained on the date of accident. I understand that this in no way relieves me of my personal primary responsibility to pay for such services, and that the signing of this form does not prohibit customary billing by you.

I further understand that my responsibility to you for payment is not contingent on any settlement, judgment or verdict and that any outstanding fees will be paid within one month of cessation of care in this office. Initial Here X___________

I authorize any insurance carrier to pay directly to my physicians such sums as may be due and owing to them. If I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any medical insurance, personal injury protection, and medical payment coverage, I agree to immediately make payment to you upon receipt of those monies.

It is further understood that the statute of limitations, in this State is three (3) years from the time services were last performed. I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I further authorize my attorney(s) upon your request to notify you of any substantial change in the status of the cause of action related to the illness or injuries described above which would affect my ability to pay for the health care services rendered. I further authorize and direct my attorney(s) to notify you should their representation of my interests in connection with the illnesses and injuries be terminated for any reason.

A photocopy of this authorization shall be as binding as an original.

DATE OF ACCIDENT (/   /   )

_____________________________   ___________________________   _____________
PATIENT NAME – PRINTED   PATIENT'S SIGNATURE   DATE SIGNED
ADDRESS:____ ACCOUNT #_____________

The undersigned attorney for the patient referred to above hereby agrees to comply fully with the foregoing, "Authorization and Assignment" and agrees to advise the named assignee, the physicians referred to above, in writing of the status of the claim of the above-named patient within ten (10) days of any request.

_____________________________   ____________________________   _______________
ATTORNEY NAME – PRINTED   ATTORNEY'S SIGNATURE   DATE SIGNED
ADDRESS:____ PHONE #___________________

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the ______________________ Insurance Company to pay by check made payable and mailed directly to:

CHIROPRACTIC FIRST
603 East Ridgeville Blvd.
Mount Airy, MD 21771

If my current policy prohibits direct payment to my doctor, then I hereby authorize you to make the check payable to me and mail as follows:

Patient's Name: ________________________________
C/O: Chiropractic First
603 East Ridgeville Blvd.
Mount Airy, MD 21771

I hereby realize that I am responsible for any health care service fees not covered by my insurance company. I am also authorizing full release of my medical records which pertain to my treatment.

Date: ____________

____
Printed Name of Policy Holder

____
Signature of Patient