

# PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Other

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Employer: \_\_\_\_\_

PATIENT'S INSURANCE	SPOUSE'S INSURANCE <input type="checkbox"/> (Check if same)
Name of Company: _____	Name of Company: _____
Address: _____	Address: _____
ID & Group #: _____	ID & Group #: _____
Phone #: _____	Phone #: _____

What is your current major complaint: \_\_\_\_\_

Specific date of injury or illness: \_\_\_\_\_  None - (Gradual Onset)

How did the injury occur:  Auto Accident  On the job  Other: \_\_\_\_\_

Does anything make the pain better: \_\_\_\_\_

Does anything make it worse: \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_

Have you been treated by a Doctor for any health condition in the last year?  Yes  No

If yes, please describe: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

**PLEASE FILL OUT THE INFORMATION BELOW ONLY IF YOUR VISIT IS RELATED TO AN AUTO ACCIDENT:**

Please explain in detail how the accident happened: \_\_\_\_\_

Driver of other vehicle (if any): \_\_\_\_\_ Insurance: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Driver of vehicle you were in (Self or other): \_\_\_\_\_

Insurance: \_\_\_\_\_ Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Contact: \_\_\_\_\_

Your attorney name and phone (if any): \_\_\_\_\_

Accident Information - Date occurred: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Number of people in your vehicle: \_\_\_\_\_ Were you the:  Driver  Passenger  Other

# CONSENT FORM

## CONSENT TO EXAMINATION AND TREATMENT

I give the doctors and staff of South OKC Chiropractic Clinic permission to perform all examinations, tests, treatments, and anything else deemed necessary or beneficial to my care. I also understand that these actions will be performed by either the doctor or an assigned staff member of South OKC Chiropractic Clinic. I further understand that I am ultimately responsible for payment of all services, and I understand that all insurance payments paid directly to this office will be credited to my account.

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Guardian (if a Minor): \_\_\_\_\_

## CONSENT TO RETRIEVE MEDICAL RECORDS

I give the doctors and staff of South OKC Chiropractic Clinic permission to collect any and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services which would be helpful in assisting in my case.

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Guardian (if a Minor): \_\_\_\_\_

## CONSENT TO RELEASE MEDICAL RECORDS

I give the doctors and staff of South OKC Chiropractic Clinic permission to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member, attorney or employer of the patient for all or part of the clinic's charge. This includes, but is not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Guardian (if a Minor): \_\_\_\_\_

## VERIFICATION OF NON-PREGNANCY (WOMEN ONLY)

By my signature below, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Assignment of Health Benefits

The parties appearing below on the \_\_\_\_ date of \_\_\_\_\_, 20\_\_\_\_, agree to the following conditions, covenants, and terms regarding the assignment of health benefits appearing the patient's insurance policy issued by (insurance company name) \_\_\_\_\_, hereafter referred to as "Insurance Company".

I, (patient name) \_\_\_\_\_, hereafter referred to as "Patient", understand and voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy with my Insurance Company in consideration for treatment rendered by Dr. Pertree, hereafter referred to as "Doctor".

That Patient, the policy holder, requests, orders, and directs his/her Insurance Company to pay the Doctor directly to his/her office at South OKC Chiropractic Clinic, the sum due Doctor for treatment rendered as a result of illness/injuries the Patient sustained. These injuries were sustained on or about the \_\_\_\_ day of \_\_\_\_, 20\_\_ (\*\*[ ] Check here if injuries were of a gradual nature\*\*).

That Patient gives Doctor the exclusive right to secure the funds assigned the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered.

That Doctor and Patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below: That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms and conditions appearing herein.

Patient: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## **Acknowledgement of Receipt of Patient Privacy Notice of South OKC Chiropractic Clinic**

By signing below, I acknowledge that I have read or received a copy of the Patient Privacy notice of South OKC Chiropractic Clinic, in force as of July 10, 2006.

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Name of Individual (printed)

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Signature of Individual (or guardian)

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Date Signed

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Witness (Office Staff)

# HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Name: \_\_\_\_\_ Patient

Date: \_\_\_\_\_

## MUSCULO-SKELETAL SYSTEM

- Low Back Pain
- Mid Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Problems
- Leg Problems
- Swollen Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Spasms
- Broken Bones

## GENITO-URINARY SYSTEM

- Bladder Problems
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urine

### FEMALES ONLY

- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain
- Lumps on Breast

**ARE YOU PREGNANT?**

YES    NO

## GENITO-URINARY SYSTEM

- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Excessive Thirst
- Nausea
- Vomiting Blood
- Diarrhea
- Constipation
- Black Stools
- Bloody Stools
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Problems

## CARDIO-VASCULAR RESPIRATORY

- Chest Pain
- Pain Over Heart
- Defficult breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problem
- Heart Problems
- Lung Problems
- Varicose Veins

## EYE, EAR, NOSE AND THROAT

- Eye Strain
- Eye Inflammation

## NERVOUS SYSTEM

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness/Vertigo
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffe/Tea/Cokes
- Drug Abuse
- \_\_\_\_\_

- Vision Problems
- Ear Pain
- Tinnitus / Ear Ringing
- Ear Discharge
- Hearing Loss
- Nose Pain
- Nose Bleeding
- Nose Discharge
- Difficult Nose Breathing
- Dental Problems
- Sore Gums
- Sore Mouth
- Sore Throat
- Hoarseness
- Difficult Speech
- Sinus Problems
- Allergies
- Jaw Pain

