Liberty Chiropractic Center

New Patient Information

Today's Date _____

Name _____ Home # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

S.S.N. _____ Date of birth _____ Occupation _____ Years ____

Employer _____ Address _____

Work Phone _____ Spouse's Name _____

Present Complaint _____

_____

Patient's relationship to insured _____

Name of insured _____ Insured S.S.N. _____

Address of insured _____

Employer of insured _____ Address _____

Insured's work phone _____ Birthdate of insured _____

Is this a work related injury? _____ How did you hear of our office? _____

Were you referred to our office? _____ If yes, by whom? _____

Are you currently under a doctor's care? _____ Doctor's name _____

Medications _____

Are you a smoker? _____ If so, how many per day? _____

FEMALE PATIENTS:

Are you pregnant or think that you may be pregnant? _____ Number of children _____

Patient Signature _____

Patient Email Address _____

Liberty Chiropractic Center

Patient Health Questionnaire

Patient Name _____ Date _____

Describe your symptoms: _____

_____

When did the symptoms start? _____ How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

How are your symptoms changing?

Getting worse Not changing Getting better

What describes the nature of your symptoms?

Sharp Numb Shooting Dull Ache
Burning Tingling

On a scale of 0-10, with 0 as no pain, what is your present level?

0 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with your normal work?

Not at all A little bit Moderately Quite a bit Extremely

How much has pain interfered with social activities?

Extremely Quite a bit Moderately A little bit Not at all

Have you had similar symptoms in the past?

Yes No

Who have you seen for your present condition?

No one other chiropractor medical doctor physical therapist
other_____

What treatment did you receive and when? _____

Please indicate any tests that you have had and when they were performed.

Xrays date ____ MRI date ____ CT scan date ____ other date ____

Who have you seen in the past for the same or similar condition.

This office other chiropractor medical doctor physical therapist
other_____

What is your occupation? _____

Full time Part time Self-employed Unemployed Other

In general, how would you describe your overall health?

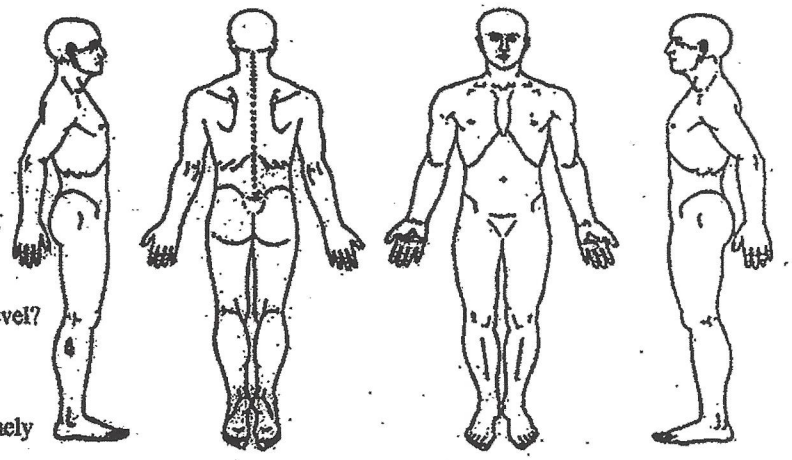
Excellent Very good Good Fair Poor

What type of regular exercise do you perform?

None Light Moderate Strenuous
How many times per week? _____

What is your height? _____ft. _____in. your weight? _____ lbs.

Please use the diagram below to indicate your pain pattern(s)



Please list all prescriptions, medications, or supplements that you are currently taking:

_____ _____

_____ _____

_____ _____

Please list all surgical procedures and any hospitalizations:

_____ _____

_____ _____

_____ _____

Please indicate if an immediate family member has any of the following:

___Rheumatoid Arthritis
___Heart Problems
___Diabetes
___Cancer
___Lupus
___other _____

Liberty Chiropractic Center

Patient Health Questionnaire – 2

Patient Name _____ Date _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
___	___	Headaches	___	___	High Blood Pressure	___	___	Diabetes
___	___	Neck Pain	___	___	Heart Attack	___	___	Excessive Thirst
___	___	Upper Back Pain	___	___	Chest Pain	___	___	Frequent Urination
___	___	Mid Back Pain	___	___	Stroke			
___	___	Low Back Pain	___	___	Angina	___	___	Smoking/Tobacco Use
						___	___	Drug/Alcohol Dependence
___	___	Shoulder Pain	___	___	Kidney Stones			
___	___	Elbow/Upper Arm Pain	___	___	Kidney Disorders	___	___	Allergies
___	___	Wrist Pain	___	___	Bladder Infection	___	___	Depression
___	___	Hand Pain	___	___	Painful Urination	___	___	Systemic Lupus
			___	___	Loss of Bladder Control	___	___	Epilepsy
___	___	Hip/Upper Leg Pain	___	___	Prostate Problems	___	___	Dermatitis/Eczema/Rash
___	___	Knee/Lower Leg Pain				___	___	HIV/AIDS
___	___	Ankle/Foot Pain	___	___	Abnormal weight gain/loss			
___	___	Jaw Pain	___	___	Loss of appetite	Females Only		
			___	___	Abdominal Pain	___	___	Birth Control Pills
___	___	Joint Swelling/Stiffness	___	___	Ulcer	___	___	Hormone Replacement
___	___	Arthritis	___	___	Hepatitis	___	___	Pregnancy
___	___	Rheumatoid Arthritis	___	___	Liver/Gall Bladder Disorder	___	___	_____
___	___	General Fatigue	___	___	Cancer	Other Health Problems/Issues		
___	___	Muscular Incoordination	___	___	Tumor	___	___	_____
___	___	Visual Disturbances	___	___	Asthma	___	___	_____
___	___	Dizziness	___	___	Chronic Sinusitis	___	___	_____

Patient Signature _____ Date _____

Doctor's Additional Comments

_____

_____

_____

_____

_____

Doctors Signature _____ Date _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

LIBERTY CHIROPRACTIC CENTER

257 W Mill Street, Liberty, Missouri 64068

Financial Responsibility

I have requested professional services from Liberty Chiropractic Center, (Provider), on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment myself and Provider upon request. On proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me from my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co- payments, co-insurance, and deductibles.

Authorization to release information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee healthcare benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any health-care expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

Liberty Chiropractic Center
Notice of Privacy Practices Acknowledgement

A Notice of Privacy Practices (NPP) is available for review to all patients. This notice identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to file a complaint if you believe your privacy rights may have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read and understands the Notice of Privacy Practices and is the patient, or the patient's legal representative.

_____	_____	_____
Name of Patient	Signature of Patient	Date Signed
_____	_____	_____
Patient's Legal Representative	Signature of Legal Representative	Date Signed

FOR INTERNAL USE ONLY

_____	_____
Name of Employee	Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:
Patient was unable to sign __
Patient refused to sign __
Other_____
_____