

Welcome

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____) _____
Cell Phone (_____) _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

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 certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)
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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

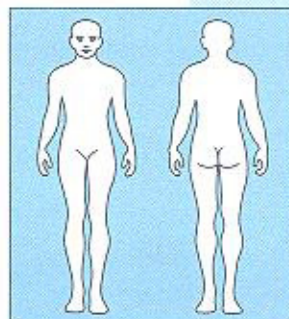
Date Relationship to Patient

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:

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

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 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 (____) _____	_____	_____

Ace Chiropractic & Optimum Health - For Life

10075 S Eastern Avenue, Suite 110
Henderson, NV 89052
702.614.8778

CONSENT FOR EXAMINATION AND TREATMENT

I understand that Ace Chiropractic & Optimum Health-For Life is a multi-disciplinary facility. I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, acupuncture and other oriental medicine procedures.

I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, burns and aggravation of disc injuries.

I understand that if I receive acupuncture and oriental medicine treatments the risks include but are not limited to: minor bleeding, local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the acts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (please print)

Date

Signature of Patient (or guardian, if patient is a minor)

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NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

(Patient May Refuse to Sign this Agreement)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgment:

You are only confirming that you have read and/or received a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health.

I have read and/or received a copy of this office's Notice of Privacy Practices.

Print your name here: _____

Sign your name here: _____

Today's Date: _____, 20_____

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FINANCIAL POLICY

We are committed to providing you with the best possible care. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer and the insurance company. We are not a party to the contract. All services rendered to you are your responsibility. However, we realize that insurance companies need processing time. All charges will become due and payable if the insurance company does not reimburse Ace Chiropractic & Optimum Health-For Life within 45 days of services rendered.

Please familiarize yourself with your insurance policy and its requirements.

As a courtesy, we will bill your insurance company. All co-pays and non-covered items are due at the time of check-in.

Collection Fees Policy: I, _____ am responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection agency due to lack of payment on my part, I agree to pay 35% of all collection/legal fees which will be added to my account.

Signature of Patient or Parent/Guardian of minor

Date: _____, 20__

Returned Checks: A \$25 non-sufficient fund fee will be charged to your account for any returned check(s) from the Bank. We report and forward all returned checks to the Clark County District Attorneys Office. Patient Initials _____

Appointment Cancellations: A 24 hour cancellation notice is required for all appointments (including Massage Therapy). Patient Initials _____