

# Patient Information:

Date \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M / F

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

Are You:  Married  Widowed  Single  Divorced  Separated  Minor e-mail \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse DOB \_\_\_\_\_ Spouse SSN: \_\_\_\_\_

Have you been to another doctor for this problem?  yes  no Who/Where? \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_

Emergency Contact (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_

Please check if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS
<input type="checkbox"/> Mumps	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pain at Night	<input type="checkbox"/> Pain on Waking
<input type="checkbox"/> Polio	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
Medications Taken:	<input type="checkbox"/> Cortisone, Prednisone	<input type="checkbox"/> Birth Control		

Please list all surgeries, injuries, accidents, etc: \_\_\_\_\_

\_\_\_\_\_

Other Medications

\_\_\_\_\_

**Current Complaint/Problem *Please list one complaint in each section***

First Problem (Symptom) \_\_\_\_\_ When did it start? \_\_\_\_\_

Symptoms getting worse?  Yes  No  Same      Rate your pain ( 1 is Mild / Discomfort, 10 is Severe pain) 1 2 3 4 5 6 7 8 9 10

Second Problem (Symptom) \_\_\_\_\_ When did it start? \_\_\_\_\_

Symptoms getting worse?  Yes  No  Same      Rate your pain ( 1 is Mild / Discomfort, 10 is Severe pain) 1 2 3 4 5 6 7 8 9 10

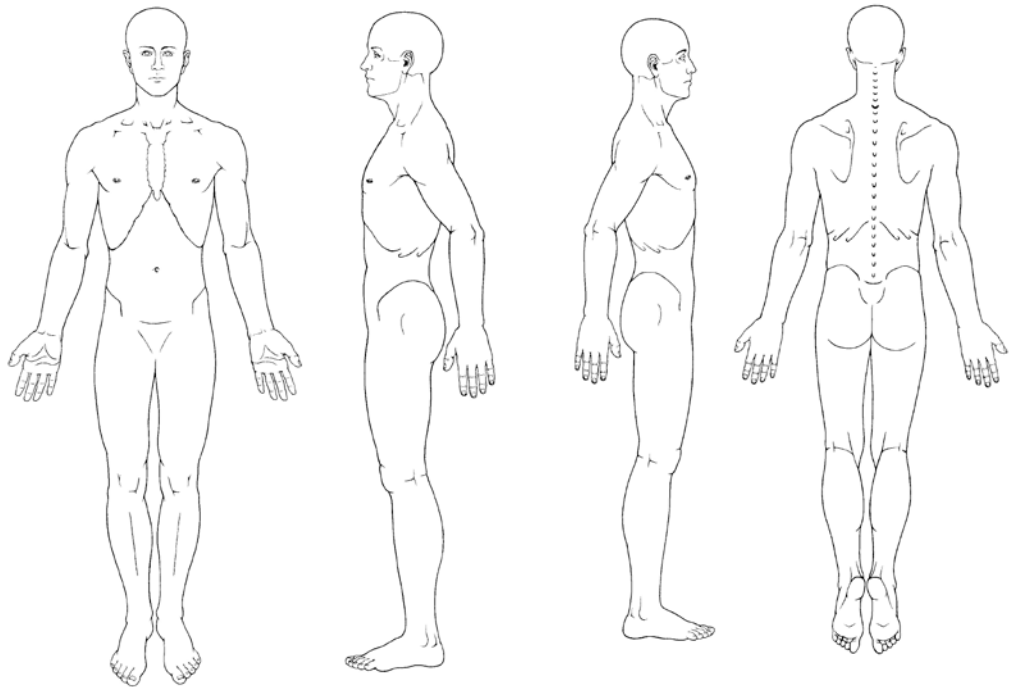
Third Problem (Symptom) \_\_\_\_\_ When did it start? \_\_\_\_\_

Symptoms getting worse?  Yes  No  Same      Rate your pain ( 1 is Mild / Discomfort, 10 is Severe pain) 1 2 3 4 5 6 7 8 9 10

Fourth Problem (Symptom) \_\_\_\_\_ When did it start? \_\_\_\_\_

Symptoms getting worse?  Yes  No  Same      Rate your pain ( 1 is Mild / Discomfort, 10 is Severe pain) 1 2 3 4 5 6 7 8 9 10

Please mark off the areas of your complaint on the diagram above with the following indicators:  
PPP = pain  
NNN = numbness  
TTT= tingling  
BBB= burning



Anything else we need to know about your health? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Insurance Account

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

Date \_\_\_\_\_

## **Responsible Party:**

Name of Person Responsible for Account  
\_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

## **Group Insurance Information**

**Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth date \_\_\_\_\_ SSN \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

## **Auto Accident Insurance Information**

**Car Insurance:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjustor's Name: \_\_\_\_\_

Phone : \_\_\_\_\_ Fax: \_\_\_\_\_

**Is there someone we can thank for referring you to this office?   Y   N**

**If yes, Name:** \_\_\_\_\_

If no, how did you find us: \_\_\_ Yellow Pages \_\_\_ Insurance Company \_\_\_ Internet Search \_\_\_ Other: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **LOCUST GROVE CLINIC, P.C.**

### **THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

In the course of your care as a patient at Locust Grove Clinic, P.C. we may use or disclose personal and health related information about you in the following ways:

\*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

\*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

\*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the

right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

\*If we provide health care services to you in an emergency.

\*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

\*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

\*If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Peter J. Tully D.C.

If you would like further information about our privacy policies and practices please contact:

Peter J. Tully D.C.

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You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of \_\_\_\_\_. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Printed please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient

