CHIROPRACTIC first
FAMILY WELLNESS CENTER

PATIENT INFORMATION
Please fill out the following information to the best of your ability

PATIENT
Last Name _____ First _____ MI____ Date_____
Address _____City_____ State _____
Zip_____Best Contact #_____ Social Sec. # ____-____-____ Birth Date ____/____/___Age_____
Male ____ Female ____Drivers license State & # _____Occupation_____
Weight_____ Height_____ Marital Status: __Married __Single __Divorced/Separated __Widowed
Are you a parent? NO YES, List Names & Ages of Children:_____
_____

EMPLOYER
( ) Not working, or Company _____
Address _____
City_____ State _____ Zip_____ Work Phone_____

SPOUSE
Last Name_____ First_____
( ) Not working outside of home, or Employed by _____
Address_____City_____State _____
Zip_____ Work Phone_____

MINORS
Parents Name _____
Signature Authorizing Care_____

NEAREST RELATIVE, NOT LIVING WITH YOU
Name _____Phone #_____Relationship_____
Address_____City_____ State_____ Zip_____

MEDICAL INSURANCE INFORMATION
Check here if no insurance ( ) (**This information is necessary for ALL patients**)
Insurance Company Name _____Group ID/No._____
Address_____City_____State _____
Zip_____
If subscriber is other than patient
Last Name _____ First _____ MI____
Address _____City_____ State _____
Zip_____Phone #_____

AUTO INSURANCE OF THE CAR YOUR WERE IN DURING ACCIDENT
Policy Holder Name_____
Ins. Company Name_____Policy No._____ Claim No._____
Address_____ Agent_____PhoneNo._____
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_____
Street Address_____ City_____ State_____
Zip_____Phone ( ) _____

IF YOU WERE NOT IN YOUR OWN CAR, WHAT INSURANCE DO YOU HAVE ON YOUR OWN CAR?
Please Note: This information is required in order to bill the insurance company of the vehicle involved in the accident. Your rates will not increase unless you were at fault and a claim is made against you by another party.
Policy Holder Name_____
Ins. Company Name_____Policy No._____ Claim No._____
Address_____ Agent_____Phone No._____

OTHER VEHICLE INSURANCE COMPANY INFORMATION
Policy Holder Name_____ Phone No_____
Ins. Company Name_____Policy No._____ Claim No._____
Address_____ Agent_____Phone No._____
Make/Model of other vehicle if known_____

WORKERS COMPENSATION INFORMATION
Employer at time of accident (same as present) or _____
Address_____ City_____State_____
Zip_____
Employer's Insurance Carrier____
Address_____ City_____State_____
Zip_____Claim #_____ Phone #_____

FRONT

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 drivers side __in the passengers side __in the front
__in the left front __in the right front
Other, explain_____

REAR

Your vehicle was struck by: __another car __pickup 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 hand turn
__slowing down for a stop sign __slowing down for a pedestrian __making a right hand 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, If Yes, Please explain _____
_____

PATIENT NAME :_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD SINCE THE ACCIDENT:

MUSCULO-SKELETAL CODE

__Low Back Pain __Walking Problems __Arm Pain __Difficult Chewing/Clicking Jaw
__Pain Between Shoulders __General Stiffness __Neck Pain __Joint Pain/Stiffness

GENITO-URINARY CODE

__Bladder Trouble __Painful/Excessive Urination __Discolored Urine

NERVOUS SYSTEM CODE

__Nervous __Numbness __Paralysis __Fainting __Convulsions __Depression
__Dizziness __Forgetfulness__Stress __Cold/Tingling Extremities __Confusion

C-V-R CODE

__Chest Pain __Short Breath __Stroke __Varicose Veins __Lung Problems
__Blood Pressure Problem __Irregular Heartbeat __Heart Problems __Ankle Swelling

GENERAL CODE

__Fatigue __Allergies __Loss of Sleep __Fever __Headaches

EENT CODE

__Vision Problems __Dental Problems __Ear Aches __Sore Throat __Stuffed Nose

GASTRO_INTESTINAL CODE

__Poor/Excessive Appetite __Vomiting __Diarrhea __Black/Bloody Stool
__Excessive Thirst __Frequent Nausea __Constipation __Heartburn
__Hemorrhoids __Liver Problems __Weight Trouble __Colitis
__Gall Bladder Problems __Abdominal Cramps __Gas/Bloating After Meals

MALE/FEMALE CODE

__Menstrual Irregularity __Vaginal Pain/Infection __Breast Pain/Lumps
__Menstrual Cramps __Prostate/Sexual Dysfunction
Other, Explain_____

FEMALES ONLY

When was your last period?_____
Are you pregnant? YES NO NOT SURE

INTAKE

__Coffee __ Tea __Alcohol
__Cigarettes __White Sugar

FAMILY HISTORY

The following members have the same or a similar problem as I do:
__Mother __Father __Brother__Sister __Spouse __Child

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__Pneumonia __Mumps __Influenza __Eczema __Small Pox __Polio
__Pleurisy __Chicken Pox __Tuberculosis __Whooping Cough __Diabetes
__Cancer __Anemia __Measles __Thyroid __Heart Disease __Lumbago
__Epilepsy __Mental Disorders __Arthritis __Rheumatic Fever __HIV Positive

Chiropractic First Family Wellness Center

Dr. Andrew Williamson & Dr. Andrea Williamson
603 East Ridgeville Blvd, Mt. Airy, MD 21771
301-829-4040

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.

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 PATIENTS SIGNATURE DATE SIGNED

_____

_____ADDRESS ACOUNT NO.

_____

_____

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 NO.

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
Mt. 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 Name &	Chiropractic First
Address	603 East Ridgeville Blvd
	Mt. Airy, MD 21771

I hearby 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:_____

_____
Signature of Policy Holder

_____
Signature of Claimant

_____
Signature of Witness

Chiropractic First

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

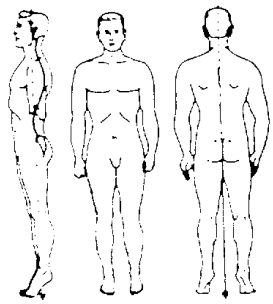
HEALTH HISTORY FORM

Patient's
Name_____Date_____/_____/_____

*****If you are NOT experiencing ANY symptoms, please go to Section B: Health History*****

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 □ Losefocus
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:
_____

PIP VERIFICATION

Date:_____ Time:_____
Spoke To: _____
Insured:_____ DOA:_____
Patient's Name:_____
Policy #:_____
Claim #:_____
Insurance Company:_____
Mail Claims To:_____
_____
Adjuster:_____
Adjuster Phone Number :_____
PIP: YES NO $_____
MED PAY: YES NO $_____

Notes_____
_____
_____
_____
_____
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