ELWERT
CHIROPRACTIC

PATIENT INFORMATION SHEET

PATIENT

Last Name:_____ First Name:_____ MI: _____

Gender: M F Date of Birth:_____/_____/_____ SS#_____

Home Address: _____ Apt#_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #:

Email Address: _____

SPOUSE or GUARDIAN

Last Name:_____ First Name:_____ MI: _____

Employer Name: _____ Work Phone #: _____

Date of Birth:_____/_____/_____ SS#_____

Relation to Patient: _____

METHOD OF PAYMENT

Insurance Company: _____

Personal Injury: YES NO If yes attorney name: _____

Workers Compensation: YES NO If yes claim number: _____

Non Insured: YES NO

Referred By: _____

Primary Physician: _____

Signature: (Patient, Parent, Legal Guardian or Responsible Party)

_____ Date: _____

If you have ever had a listed symptom in the past, please check that symptom in the past column. If you are presently troubled by a particular symptom, check that symptom in the Present column. Most manifestation code listings are provided for the doctor's reference.

PAST	PRESENT	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain In Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting, Visual Disturbances, Nausea
☐	☐	(780.2)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (788.50)
☐	☐	Loss of Appetite (783.0)
		Abnormal Weight ☐ Gain (783.1)
		☐ Loss (782.2)
☐	☐	Excessive Thirst (783.6)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)

Present: Weight_____pounds
Height_____feet_____inches

PAST	PRESENT	
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Vaginal Discharge (623.5)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/Irregular bowel habits
☐	☐	(564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dormatitis/Eczema/Rash (692.9)

Please check any of the following that apply to you.

☐	☐	Tobacco Use (305.1)
☐	☐	Alcohol Use (305.0)
☐	☐	Birth Control Pills Used
☐	☐	Medications (please list them) _____
		_____
		_____
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list them) _____
		_____
☐	☐	Coffee/Tea/Caffeinated Soft Drinks, Cups Per Day: _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

PAST	PRESENT	CONDITION
☐	☐	Depression (311)
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Anolna (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Prostate Problems (601.9)
☐	☐	Anorexia (783.0)
☐	☐	Blood Disorder (790.6)

PAST	PRESENT	CONDITION
☐	☐	Emphysema (chronic lung disorders)
☐	☐	(492.8)
☐	☐	Arthritis (716.9)
☐	☐	Diabetes (250.0)
☐	☐	Ulcer (556.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (556.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Other:_____

FAMILY HISTORY: **PAST OR PRESENT HEALTH PROBLEM**

Mother: _____
Father: _____
Brothers: No. of () _____
Sisters: No. of () _____
Patients Signature: _____ Date: _____

ELWERT
CHIROPRACTIC

WAIVER FORM

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE EXACTLY WHAT THOSE GUIDELINES ARE. UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENT IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES, SUCH AS LAB WORK, MRI OR X-RAYS, THAT ARE NOT COVERED WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. PAYMENTS FOR THOSE CHARGES ARE THEN YOUR RESPONSIBILITY. AS THE POLICY HOLDER, ***YOU ARE RESPONSIBLE*** FOR KNOWING THE BENEFITS AND RESTRICTIONS OF YOUR INSURANCE COVERAGE.

I UNDERSTAND THAT SHOULD MY INSURANCE REQUIRE A ***REFERRAL/AUTHORIZATION*** PRIOR TO MY RECEIVING MEDICAL SERVICE AND I HAVE NOT OBTAINED THIS AND/OR THIS OFFICE HAS NOT RECEIVED THIS, ***I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED***.

I UNDERSTAND THAT SHOULD IT BECOME NECESSARY TO PLACE MY ACCOUNT WITH AN OUTSIDE COLLECTION AGENCY THERE WILL BE AN ***ADDITIONAL 30% PENALTY*** ADDED TO MY DELINQUENT BALANCE.

THIS IS TO VERIFY THAT _____WHOSE SIGNATURE IS AFFIXED BELOW, WAS INFORMED IN ADVANCE THAT ANY NON-COVERED SERVICE OR SERVICES DONE WITHOUT COVERAGE THROUGH INSURANCE WILL BE THE RESPONSIBILITY OF THE PATIENT.

THIS INCLUDES X-RAY CHARGES FOR MEDICARE PATIENTS, WHICH IS NOT COVERED IN A CHIROPRACTOR'S OFFICE.

ANY WORKMAN'S COMPENSATION CLAIM THAT IS DENIED WILL BE THE RESPONSIBILITY OF THE PATIENT.

ANY PERSONAL INJURY CLAIM THAT IS FILED THROUGH MEDICAL INSURANCE AND NOT PAID BY THE INSURANCE COMPANY WILL BECOME THE RESPONSIBILITY OF THE PATIENT.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE_____ DATE_____

Elwert Chiropractic

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Elwert Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and **(give my permission / don't give permission)** to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $35 - $70

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Todd S. Elwert D.C.
5616 Cheviot Rd
Cincinnati,Ohio 45247
513-741-4700

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Todd S. Elwert D.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Your care will be rendered in an open facility. If you request a private room we will accomodate you to the best of our ability.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

PAIN DISABILITY QUESTIONNAIRE

NAME _____ DATE _____

IS YOUR PAIN- CONSTANT 76%-100%___, FREQUENT 51%-75%___,
INTERMITTENT 26%-50%___ OR OCCASIONAL____?

USE THE LETTERS BELOW TO INDICATE THE TYPE AND THE LOCATION OF YOUR SENSATION RIGHT NOW

KEY:	**A=ACHE**	**B=BURNING**	**N=NUMBNESS**
	P=PINS & NEEDLES	**S=STABBING**	**O=OTHER**

PLEASE GRADE YOUR PAIN LEVEL ON THIS SCALE.(PLEASE CIRCLE A NUMBER)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORSE).