Whitestone Chiropractic

Name _____ Home Phone _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

Birth date _____ Age _____ SS# _____

Occupation _____ Employer _____

Marital Status: M W S D Spouse Name: _____ No. of Children _____

E-mail Address: _____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? _____

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ ☐ Never

3. When was your last complete spinal examination? _____ ☐ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

Low - 1 2 3 4 5 6 7 8 9 10 - High

8. Please list any health symptoms or health complaints you are experiencing.

1. 2. 3.

_____

9. Have you had any surgery or broken bones? If yes, please list below:

_____

_____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

_____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ YES ☐ NO Date of Incident _____

13. Do you currently have health insurance? YES NO

14. If yes, please provide:

Insurance Company Name: _____ Member Number: _____

The above information is true and accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Have you ever suffered from:

- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep issues/Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis Ulcers
- ☐ Varicose Veins

Whitestone Chiropractic Office

214-11 41st Avenue Bayside, N.Y. 11361

(718) 352-0223

Patient Privacy Notice

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care options.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those who feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we might have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment, and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use of disclosure of your PHI. This refusal must be made in writing. Under HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of your PHI. The refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or previously signed consent

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____

Signature **Print Name** **Date**

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Patient Health Information can only be discussed with the patient. We will disclose patient health information to parents/ legal guardians of patients under the age of 18. If you would like us to disclose information concerning medical conditions, test results, treatment and all other patient health information with someone other than yourself please list full names below:

_____

_____

A parent/legal guardian for treatment must accompany children 17 and younger. If you wish to permit other adults {18 or older) to bring your child for treatment, please indicate their names below:

Name **Relationship**

_____

_____

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Authorization for Signature on File

Name of Patient: _____ Beneficiary #: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

_____ _____

Signature **Date**

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____ _____

Signature **Date**