Wright Chiropractic

Dr. Loren W Wright, D.C.
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Las Vegas NV 89131
(702) 318-4774 Fax (702) 318-4775

Confidential Patient Health Records
Date: _____
I. D. NO. _____

PERSONAL INFORMATION

Name: _____MI_____
Nickname: _____ Age: _____
Address: _____
City/ State: _____Zip: _____
SS# _____ Gender: M F
Marital Status: Married Divorced Single Widowed
D.O.B._____ HT _____ WT _____
Circle your preferred phone number to contact:
Home: _____ Cell: _____
Email: _____

Employer: _____
Occupation: _____Work # _____
Spouses Name: _____D.O.B._____
Spouses Employer: _____Work # _____
Spouses SS# _____
Who may we THANK for referring you to this office?
Family/Friend if so who? _____
Insurance Co: _____ Internet____
Doctors Office: _____Yellow pages ___
Attorney: _____
Other:_____

CURRENT HEALTH CONDITIONS

Reason for this visit to our office: _____
Other Doctors Seen For This Condition: Yes / No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? Date_____ Has This Condition Occurred Before? Yes/ No When? _____
Is Condition: Job Related ___ Auto Accident ___ Home Injury ___ Fall ___ Other _____
Date of Incident _____ Have You Made A Report of Your Accident With Your Employer: Yes/ No
Have You Lost Any Work? Y/ N Day You Last Worked: _____
Do You Now Take: Pain Killers____ Muscle Relaxer ____ Blood Pressure Medicine ____ Insulin ____
Other Medications: _____
Are You Allergic To Any Medication? Y/N What? _____Do You Wear A Shoe Lift? Yes/ No
Do You Suffer From Any Conditions Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Date all Surgery/ Operations: Appendectomy __ Date: _____ Tonsillectomy __ Date_____
Gall Bladder__ Date: _____ Hernia __ Date: _____ Back Surgery__ Date: _____
Neck Surgery __ Date: _____ Cosmetic Surgery__ Date: _____
Replacement Surgery (hip, knee, etc.) Y/N Date _____What was replaced: _____
Broken Bones __ Date: _____ Dislocations Y/N Date: _____
Major Accidents or Falls: _____ Hospitalization: _____
Other Surgeries and Dates: _____
Previous Chiropractic Care: Yes/ No Doctor's Name and Approximate Date of Last Visit: _____

INSURANCE INFORMATION

You and/or Spouse___ Health Ins: ___Workers Comp: ___ Case # _____ Auto Ins.: ___Case # _____
Medicare: ___ Health Ins. Name: _____ Health Card # _____
Insured Person's Name: _____Soc Sec # _____ D.O.B._____

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

Anemia Arthritis Cancer Diabetes Epilepsy Heart Disease Mental Disorders
Pneumonia Osteoporosis Thyroid Rheumatic Fever

CIRCLE CURRENT SYMPTOMS

MUSCULO- SKELETAL

Low Back Pain Pain between Shoulders Mid Back Pain Neck Pain Arm Pain Leg Pain
Walking Problems Joint Pain/ Stiffness General Stiffness Headaches Fatigue Allergies
Loss of Sleep Confusion/Depression Paralysis Dizziness Forgetfulness Fever
Fainting Seizures/ Convulsions Nervous Stress
Numbness Where? _____ Cold / Tingling Extremities Difficulty Chewing/ Clicking Jaw

GASTROINTESTINAL

Poor/ Excessive Appetite Excessive Thirst Frequent Nausea Vomiting Diarrhea
Gall Bladder Problems Liver Problems Weight Troubles Heartburn Colitis
Gas/ Bloating after meals Constipation Black/ Bloody Stools Abdominal Cramps

GENITO-URINARY

Bladder Trouble Painful/Excessive Urination Discolored Urine

C-V-R

Chest Pain Short Breath Blood Pressure Problems Irregular Heartbeat Heart Problems
Lung Problems/Congestion Ankle Swelling Stroke

EENT

Vision Problems Dental Problems Sore Throat Ear Aches Hearing Difficulty Stuffed Nose

MALE /FEMALE

Menstrual Irregularity Menstrual Cramps Vaginal Pain/ Infection Breast Pain/ Lumps
Prostate/Sexual Dysfunction Other Problems

(Women Only) Are you or do you think you may be pregnant? Y/ N Due Date: _____Nursing? Y/ N

Have You Had Any of the Following Recently:

Blood Test: Y/N Date:_____ Urinalysis: Y/N Date: _____ Radiation Treatment: Y/N Date _____
MRI: Where? _____ When? _____
X-Rays: Where? _____ When? _____
Other Special Treatments: _____

Do you Smoke Y/N If Yes, how many a day? _____ Do you Drink Alcohol? Y/N If yes how much? _____
Do you Take any Vitamins? Y/N What kind? _____
Do you exercise Regularly? Y/N What kind? _____ How Often? _____

Have you ever had cancer? Y/ N
Do you faint easily? Y/N
Have you had any loss in bladder or bowel control? Y/N
Does the pain wake you from a sound sleep Y/N
Have you lost or gained weight in the past year? Y/N
Have you lost consciousness or had double vision recently? Y/N
Are you coughing up blood or noticing it in your blood or stools? Y/N

FAMILY HISTORY

Does your immediate family have any of the following?

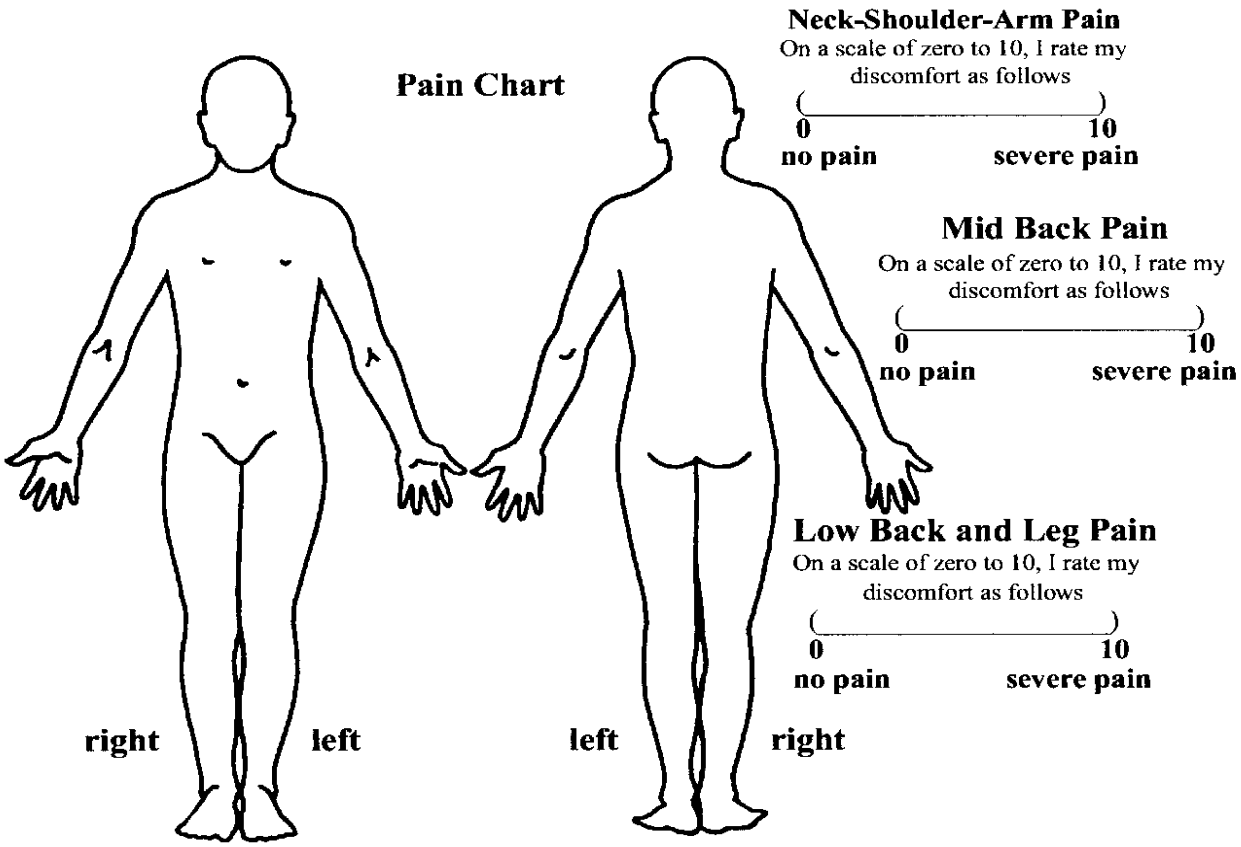
High Blood Pressure Y/N Heart Attack Y/N Cancer Y/N Stroke Y/N
Seizures- Convulsions Y/N Asthma Y/N Diabetes Y/N Arthritis/Rheumatism Y/N

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Date: _____ Signature _____

Health Care Authorization Form

Patient's Name _____
Patient's SS # _____Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **WRIGHT CHIROPRACTIC** TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Please Initial **SPECIFIC AUTHORIZATIONS**

_____ I give permission to **Wright Chiropractic** to use my address, phone number, and clinical records to verify and bill my insurance.

_____ I give permission to **Wright Chiropractic** to use my address and phone number to contact me with appointment reminders and missed appointment notification.

_____ I give permission to **Wright Chiropractic** to use my address to send me Birthday cards, thank you cards, and patient appreciation invitations.

_____ If **Wright Chiropractic** contacts me by phone, I give them permission to leave a message on my answering machine or voice mail.

By signing this form you are giving **Wright Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: Indefinite

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Wright Chiropractic**. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;

The date of your request;
Your signature.

The revocation is not effective until it is received by the Privacy Official.

The AUTHORIZATION is requested by **Wright Chiropractic** for its own use/disclosure of PHI. (Minimum necessary standards apply)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **Wright Chiropractic** will not refuse to provide treatment.

You have the right to inspect or copy PHI to be used /disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST

Print Name of Patient_____

Signature of
Patient_____Date_____

Signature of Personal Representative_____

☐ I have read and or received the "Notice of Privacy Practices for Protected Health Information."

Financial Policy

Thank you for choosing Wright Chiropractic as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you read, and sign prior to any treatment.

All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
We accept cash, checks, or Visa/Mastercard/Discover.

Regarding Insurance
Billing your insurance is a courtesy that we provide. We may accept assignment of insurance benefits. The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not accept assignment of benefits we require that you pay for your care as services are rendered.

Regarding insurance plans, where we are a participating provider all co-pays and deductibles are due at the time of service prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, please refer to the above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for <u>full payment</u>. In the event of non-payment on your part, you are responsible for any and all collection and/or legal fees.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for <u>full payment</u>. For unaccompanied minors non-emergency treatment will be denied unless charges have been pre authorized to an approved credit plan, Visa or MasterCard, or payment by cash or check, at the time of service, has been verified.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party

Signature on File

Please initial and sign below. Thank you.

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of pertinent information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

_____ I authorize payment direct to my doctor.

_____ I permit a copy of this authorization to be used in place of the original.

I give Dr. Loren Wright Authorization to treat my condition as he deems appropriate.

Name_____
(Please print)

Signature_____

Date_____