Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

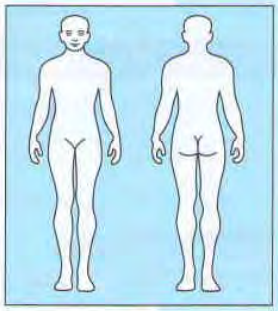
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No			
		Measles	☐ Yes ☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that **Gordon Chiropractic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Gordon Chiropractic's** Notice of Privacy Practices prior to signing this document. Gordon Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Gordon Chiropractic**. The Notice of Privacy Practices for Gordon Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Gordon Chiropractic's** duties with respect to my protected health information.

Gordon Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____
Patient Signature Date

Permission to Administer Treatment

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

_____ _____
Patient Signature Date

To help expedite processing of your insurance claims, we ask that you answer the following questions concerning the nature and onset of your symptoms.

1. Is the reason for seeing the doctor due to an automobile or work related injury? [ ] YES [ ] NO

2. Are you currently under care by any doctor for an automobile or work related injury? [ ] YES [ ] NO

The above information is true to the best of my knowledge. My signature below is an authorization to release this information to my insurance carrier.

_____ _____
Patient Signature Date

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
Patient Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

_____ _____
Patient Signature Date

THE NATURAL WAY
GORDON
CHIROPRACTIC
7887 COOLEY LAKE ROAD, SUITE 120 · WEST BLOOMFIELD, MI 48324
(248) 366-3300 · FAX (248) 366-3396 · gordondc.com

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic examinations, diagnosis, and analysis.

Like all forms of health care, Chiropractic care offers considerable benefits. However, as with all for of health care, the practice of chiropractic involves some risks to treatment including, but not limited to; fractures, disc injuries, strokes, dislocations, and sprains. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury.

I understand that the doctor will use his hands and/or a mechanical device upon my body during treatment. The doctor will not give any treatment or health care if he/she is aware that such care may be contraindicated (a condition which makes a particular treatment or procedure inadvisable). Again, it is the responsibility of the patient to make it known, or to learn through heath care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to attention of the Chiropractic Physician.

The Chiropractic Physician provides a specialized, non-duplicating health care service. Our Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a Chiropractic Physician at Gordon Chiropractic, I am authorizing them to proceeds with any treatment and/or adjunct therapies that may be necessary. There has been no promise, implied or otherwise, of a cure for any symptom, disease or conditions as a result of treatment at Gordon Chiropractic. I have had an opportunity to speak with a Chiropractic Physician at Gordon Chiropractic. All my questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction and the benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient Name (Print)	**Patient or Legal Guaridan Signature**
Relationship to Patient	**Date**
Witness Signature (Office Staff)	**Date**

THE NATURAL WAY
GORDON
CHIROPRACTIC

7887 COOLEY LAKE ROAD, SUITE 120 · WEST BLOOMFIELD, MI 48324
(248) 366-3300 · FAX (248) 366-3396 · gordondc.com

Gordon Chiropractic EHR Access Form

Patient Name: _____Date: _____

Email Address (for access to your electronic health records):

_____

Demographics:

1. Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
2. Ethnicity: Hispanic _____ Non-Hispanic _____
3. Preferred Language: English _____ Spanish _____Other _____
4. Race: White/Caucasian _____
   African American _____
   Native American _____
   Hawaiian/Pacific Islander _____
   Other _____

Medications:
Please list all medications you are currently taking and their **dosages**:

_____
_____
_____
_____
_____
_____
_____

Are you allergic to any medications? If so, please list them & the reaction below:

_____
_____
_____
_____

Smoking Status:
Do you currently smoke or use other tobacco products? Yes _____ No _____
If you are a current tobacco user:
What type of tobacco do you use (cigars, cigarettes or chew) _____
How much per day? _____
Have you ever tried to quit (if so, what methods have you used)?

_____
_____
_____

**********OFFICE USE ONLY**********

Vital Signs: Height _____ Weight _____ BP _____ Pulse _____