Patient Health History

Today's Date _____ **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Please PRINT

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Mobile Phone_____**Home Phone** _____

Secondary Phone _____

Home email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method *(check one)*

❑ Mobile Phone ❑ Home Phone ❑ Secondary Phone ❑ Home Email

Date of Birth _____ **Age** _____ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one for patio)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ Black/African American ❑ Caucasian ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other_____ ❑ I choose not to specify

Street Address _____

Zip Code _____ **City/ State** _____

Mailing Address (If different then Street Address) _____

Zip Code _____ **City/ State** _____

Were you referred to our office? If so, by whom: _____

Chief Complaints *(check apply that apply)*

❑ Neck ❑ Ribcage ❑ Elbow R L ❑ Hip R L ❑ Ankle R L
❑ Mid Back ❑ Abdomen ❑ Forearm R L ❑ Leg R L ❑ Foot R L
❑ Low Back ❑ Shoulder R L ❑ Wrist R L ❑ Knee R L ❑ Headaches
❑Chest ❑ Upper Arm R L ❑Hand R L ❑ Calf R L ❑ Other: _____

Have you had any recent bodily trauma? (i.e., a slip and fall) ❑ Yes ❑ No
If yes, please describe: _____

Are you Pregnant?❑ Yes ❑ No If yes, how far along: _____

❑ Health Insurance **PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARDS AND IDENTIFICATION**

CONTINUED ON BACK

The SUBSCRIBER'S information:

Name _____ **DOB** _____ **SS#**_____ **Relation** _____

q OUT OF POCKET/ NO INSURANCE

❑ Motor Vehicle Accident **DATE OF MVA**: _____/_____/_____ **STATE MVA OCCURRED**: _____**CLAIM SUBMITTED** ❑Yes ❑No **CLAIM:** _____ **INSURANCE CO:** _____

ADJUSTER: _____ **PHONE:** _____ **FAX:** _____**PIP COVERAGE**_____

ATTORNEY/LAW FIRM: _____ **PHONE**: _____ **FAX**: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		**5)** _____	
2) _____		**6)** _____	
3) _____		**7)** _____	
4) _____		**8)** _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____pounds **BP:** _____ / _____

Rice Chiropractic Clinic
Dr. Eliseo Cummings, D.C.
204 North First Street Conroe, Texas 77301

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI 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. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. 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.

I, _____ (print) acknowledge that I have reviewed the above information and **give my permission** to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT give my permission** to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above-named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility. **I instruct checks to be made payable to Rice Chiropractic Clinic, and the payment sent to 204 N. First St. Conroe, Texas 77301.**

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above-named doctor and/or treating facility upon receipt of my settlement award(s).

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and the probability of adverse reaction due to ancillary procedures is also considered “rare”.

• I, the undersigned **parent, or legal guardian of** _____ (**minor child**), hereby give my permission to the staff of Rice Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case. By signing below, I agree to the terms I have read above.

Patient or Parent Signature: X_____ Date: _____