Rinn CHIROPRACTIC
Steamboat Springs, CO

File _____ Today's Date _____

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Mailing Address:_____ (City, State, Zip): _____

Social Security #: _____ Sex: □ M □ F Marital Status: □ Single □ Married □ Widowed □ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Name: _____ Maiden Name: _____ Email: _____

Employment Information

Employment Status: □Employed □Part-time Student □Full-time Student □Other:_____

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information (Legal Guardian if Patient is under 18 Years of Age)

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #:_____ Responsible Party Phone #_____ Relationship to Patient: _____

Employer: _____ Occupation: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID #: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name (First, Middle, Last): _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone:_____ Relationship to Patient:_____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to the Following?

□Employment □Emergency □Accident □Auto Accident (State of Auto Accident) _____

If employment related, has employer been notified? □Yes □No Employer Contact Name: _____

Employer Contact Phone and Extension: _____ Family Medical Doctor: _____

How Were You Referred to Our Office?

□By an Attorney □By a Doctor □By a Patient □Yellow Pages □Other: _____ Print the name of your source: _____

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History of Present Complaint

Chief Complaint: _____ Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Have you ever had the same or a similar condition? □Yes □No

If yes, when? _____ Please describe: _____

Days lost from work: _____ Date of last physical examination: _____

What does this prevent you from doing or enjoying? _____

If this is a recurrence, when was the first time you noticed this problem? _____ How did it originally occur? _____

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually Worse If yes, how and when? _____

How frequent is the condition? □ Constant □ Daily □ Intermittent □ Night Only

How long does it last? □ All Day □ Few Hours □ Minutes

Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □ Aching □ Burning □ Stabbing □ Other: _____

Is there anything you can do to relieve this problem? □ Yes □ No If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Other: _____

Are there any other conditions or symptoms that may be related to your symptom? □ Yes □ No If yes, describe: _____

List any major accidents that you have had other than those that might be mentioned above: _____

Are there other health problems or problems you would like the doctor to evaluate? □ Yes □ No

If yes, describe: _____

WOMEN ONLY: Are you pregnant or is there any possibility you might be pregnant? □ Yes □ No □ Uncertain Last Mammogram was _____

Past Medical History

Have you ever been diagnosed as having or suffered from any of the following? (Place a check mark by the conditions that apply):

□ Broken or Fractured Bones	□ Osteoarthritis	□ Eating Disorder
□ Circulatory Problems	□ Epilepsy	□ Alcoholism
□ Rheumatoid Arthritis	□ Pace Maker	□ Drug Addiction
□ Seizures/Convulsions	□ Strokes	□ HIV Positive
□ A Congenital Disease	□ Cancer	□ Gall Bladder
□ Excessive Bleeding	□ Ruptures	□ Depression
□ High/Low Blood Pressure	□ Coughing Blood	□ Ulcers

Do you have a history of stroke or hypertension? □ Yes □ No If yes, when? _____

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates):_____
_____

Have you been treated for any health condition by a physician in the last year? □ Yes □No If yes, describe: _____

What medications or prescription drugs are you taking?
_____Dosage:_____

Do you have any allergies, especially to Medications?
_____

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Social History

Do you drink alcoholic beverages? □ Yes □ No If yes, how much per week? _____

Do you use any tobacco products? □Yes □No Do you smoke? □ Yes □ No If yes, how often? _____ When did you quit? _____

Do you take vitamin supplements? □ Yes □ No If yes, please list: _____

Do you consume caffeine? □ Yes □ No If yes, how much per day? _____

Do you exercise? □ Yes □ No If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

Does your present condition limit your work or hobbies?_____

What percentage of the time during the day do you spend: Lifting: _____ Sitting: _____ Bending: _____ Working at a computer: _____

Family History

Father: □ Living □ Deceased Current age if still living: _____ Cause and date of death if deceased: _____

Mother: □ Living □ Deceased Current age if still living: _____ Cause and date of death if deceased: _____

Check if applicable: □ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES: (Check if applicable and indicate whether family member is **F**ather, **M**other, **B**rother, **S**ister):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetes _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritis _____	Liver Disease _____	Other _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment benefits. I understand that I am financially responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Rinn Chiropractic Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. By my signature below, I acknowledge that I have read, understand and that I have been advised that if it becomes necessary to use and outside collection agency/credit reporting agency to secure payment of the balance due, a 30% fee will be added to my account. I thus agree to pay all costs of collection, including attorney fees and waive my exemption under the constitution of laws of the State of Colorado.

Patient Signature Date

Guardian Signature Authorizing Care Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. We may contact you by telephone or mail for appointment reminders, announcements, newsletters, post cards, or to check on your condition/status. We may also contact you to inform you about our practice and its staff or for any future special events.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Signature (patient / legal guardian) Date