Thorpe Chiropractic Office

Dr. Kent R Thorpe

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____Cell Phone Carrier_____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security#_____-____-_____Occupation_____Employer_____

Referred by: _____Emergency Contact:_____

Relationship to Emergency contact_____Phone_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

Language:__English__Spanish__Indian__Japanese__Chinese__Korean__French__German__Russian__Other

Do you authorize text reminders? __Yes__No Do you authorize e-mails?__Yes__No

Contact Preference __Home__Work__Cell__E-mail__Post mail

Ethnicity__Caucasian (non-Hispanic)__African American (non- Hispanic)__Native American/Alaskan__Hispanic/Latino __Asian__Middle Eastern__Pacific Islander__Other_____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Insurance ID# :_____ Insurance Company :_____
Policy Holder's Employer: _____ Claim#: (auto accident) _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____
Policy Holder's Employer: _____
Insurance ID# :_____ Insurance Company :_____

212 Highbridge Street, Fayetteville, NY 13066
Phone: (315) 637-0706 Fax: (315) 637-0708
www.thorpe-dc.com

Date: _____

Patient Name: _____

1. **Reasons for seeking chiropractic care:**

Primary reason:
_____

Secondary reason:
_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
_____
_____
_____

3. **Past Health History:**
   - **A. Please indicate if you have a history of any of the following:**
     □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
     □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
     □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
     □ None of the above
   - **B. Previous Injury or Trauma:**
     _____

     Have you ever broken any bones? Which?
     _____
   - **C. Allergies: _____**
   - **D. Medications:**

Medication Reason for taking
_____
_____
_____
_____

   - **E. Surgeries:**

Date Type of Surgery
_____
_____
_____
_____

   - **F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery Outcome
_____
_____
_____
_____

4. **Family Health History:**
   Do you have a family history of? (Please indicate all that apply)
   □ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
   □ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
   □ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death Age at death
_____
_____
_____

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Social and Occupational History:

A. **Job description:**
_____

B. **Work schedule:**
_____

C. **Recreational activities:**
_____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**
_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

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Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. David A. Thorpe, DC, DACBOH, CME of Thorpe Chiropractic Office for services performed.

Patient or Guardian Signature _____
Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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