Patient Information

New Patient Information

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss

First Name ______________________

Middle Name ______________________

Last Name ______________________

☐Insurance ☐Work Comp ☐Personal/Auto Injury

Address

Street ______________________

____

City ______________________

State Zip

Personal Information

☐Female ☐Male

SS# ______________________

Driver License# ______________________

Birth date ______________________

☐Divorced ☐Married ☐Single ☐Widow(er)

PCP: ______________________

PCP Phone No:

Communications

Home Phone # ______________________

Cell Phone # ______________________

Email

Employment

☐FT ☐PT ☐Retired ☐Unemployed

Employer ______________________

Work Phone # ______________________ Ext.

Occupation

Student

☐Full Time ☐Part Time ☐None

School

Misc:

Referral

Referred By:

Primary Insurance Information

Company ______________________

Policy/Group # ______________________

Address ______________________

____

Phone # ______________________

Insured's Name ______________________

Relation ______________________

Insured DOB ______________________

Insured SS#

Secondary Insurance

Company ______________________

Policy/Group # ______________________

Address ______________________

____

Phone # ______________________

Insured's Name ______________________

Relation ______________________

Insured DOB ______________________

Insured SS#

Please review all above information

If there aren't any changes initial below.
If there are changes please let us know so that we can update your file

Year	Patient Initials

PATIENT INTAKE FORM

Name ____________________ Height __________ Weight __________ Age ________

What is your major complaint?

Have you ever had chiropractic care before? ☐ Yes ☐ No
If Yes, when? ______________

Is this condition due to a(n)
☐ Auto accident
☐ Work injury
☐ Illness
☐ Unknown
☐ Other accident

Are the symptoms...
☐ Improving
☐ Getting worse
☐ About the same
☐ Intermittent (come & go)

Date symptoms appeared ______________

Check any activities that aggravate your condition.
☐ Bending
☐ Standing
☐ Coughing
☐ Twisting
☐ Lifting
☐ Walking
☐ Lying Down
☐ Other _______
☐ Sitting

Have you seen another provider for this condition? ☐ Yes ☐ No
If Yes, please complete the following information:
Provider's Name ________________
Date Consulted ________________
Diagnosis:

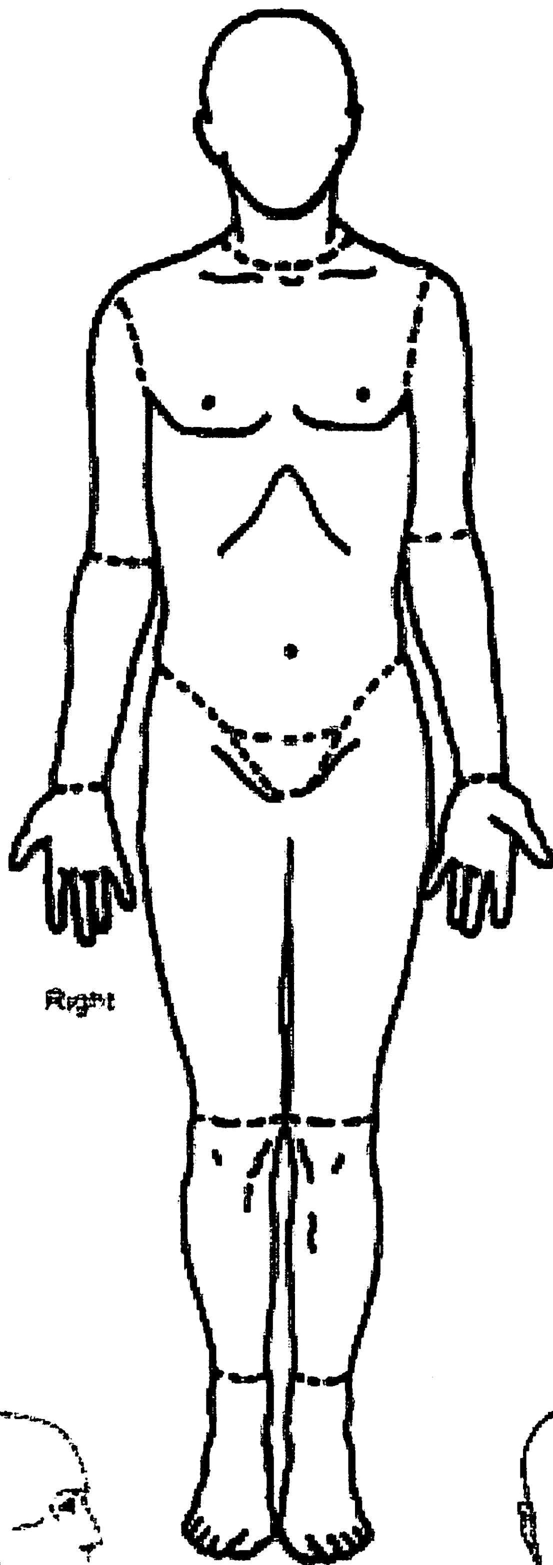
☐ Acupuncturist
☐ Neurologist
☐ Chiropractor
☐ Orthopedic
☐ Dentist
☐ Osteopath
☐ Massage Therapist
☐ Podiatrist
☐ MD
☐ Other _______

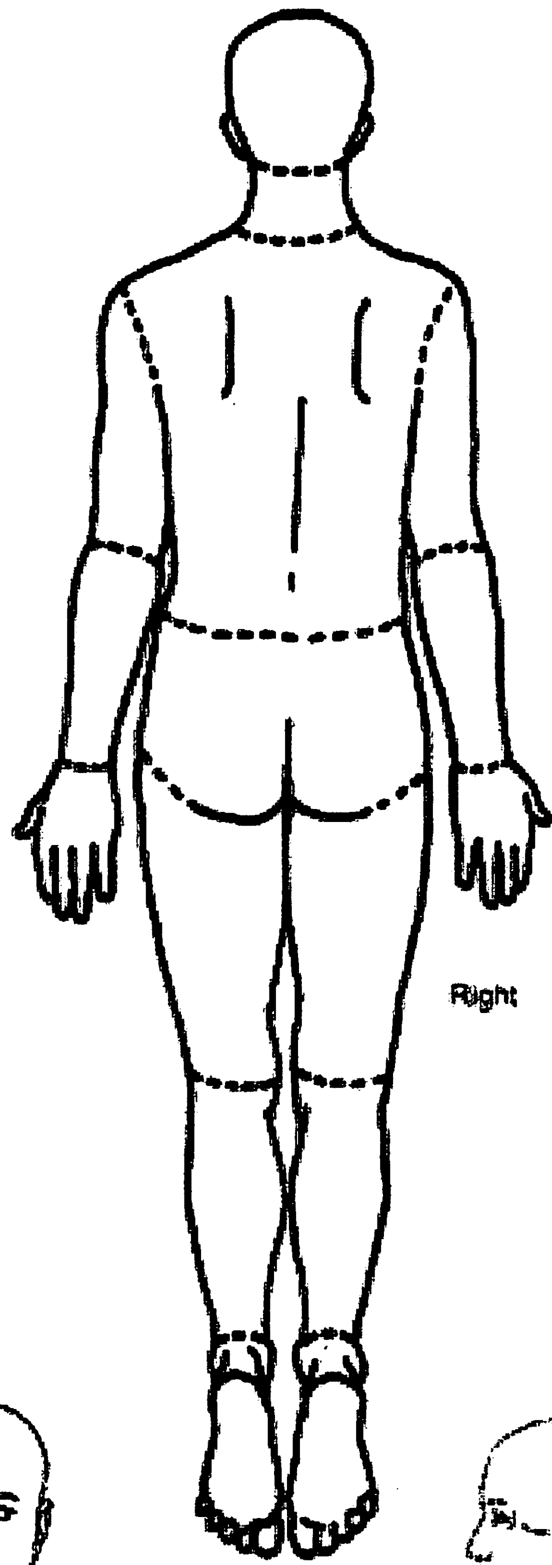
Have you ever had any surgeries? ☐ Yes ☐ No
If Yes, for what and when

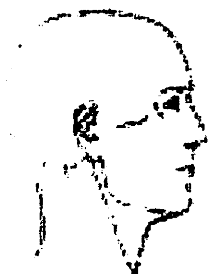
____

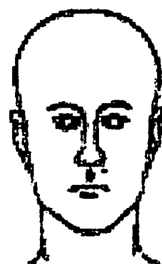
Please check any of the following medications you are currently taking.
☐ Aspirin
☐ Insulin
☐ Anti-Depressant
☐ Pain Killers
☐ Anti-Inflammatory
☐ Tranquilizers
☐ Birth Control
☐ Other _______

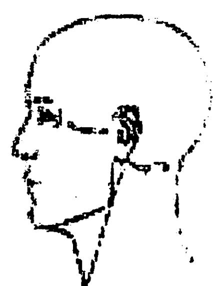
Please mark on these pictures where it is you hurt











CHIROPRACTIC HEALTH CENTER OF BRISTOL, LLC
22 PINE STREET, SUITE 216
BRISTOL, CT 06010
860.583.4346/ Fax: 860.583.0667
www.backdoc.com

David M. Spitz, DC*
*Board Eligible Chiropractic Neurology

Missed Appointments:

If for any reason you cannot keep your scheduled appointment, please call to reschedule within 24 hours of your appointment. **It is our policy to charge $25 for a missed appointment**. This charge is the patient's responsibility and cannot be charged to an insurance plan. Please help us to serve you and other patients ***by keeping your scheduled appointments!***

Thank you for understanding our appointment policy. Everyone benefits when definite arrangements are agreed upon in advance. If at any time, you have questions or concerns, please don't hesitate to ask one of our staff or call 860-583-4346.

I have read, understand and agreed to the above.

____
Print Name

______________________________ ______________________________
Patient's Signature **Date**

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

______________________________ ______________________________
Signature of Representative **Relationship to Patient**

______________________________ ______________________________
Witnessed ***Date***

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David M. Spitz, DC

AUTHORIZATION FOR RELEASE OF RECORDS
Pertaining To:
PERSONAL HEALTH RELATED INFORMATION

Patient Name: ____ (print)

RECORDS REQUESTS:
By signing below, I hereby authorize the release of all medical records, to the Chiropractic Health Center of Bristol, which may be pertinent to the current health condition for which I am seeking care, and any other reason which may be deemed necessary now or in the future. I authorize the release of this information for the purpose evaluation and management of my health care. This information may also be used for the following reasons:

____

____

____

____

RECORDS RELEASES:
By signing below, I hereby authorize the Chiropractic Health Center of Bristol to release my medical records to any other health care provider or individual who has provided an authorized records request, valid reason for request, and proper identification, all of which will be entered into my medical records. Please check any of the following reasons and/or list any reason, condition or authority that you DO NOT want your information released to or used for:

☐ Referral Board ☐ Periodic Mailings ☐ Patient of the Month ☐ Testimonials ☐ Other:

____

____

SIGNED: ______________________________________ **DATE:** ______________
A photocopy of this signature and form shall serve as the same as the original.

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

______________________________ ______________________________

Signature of Representative **Relationship to Patient**

I understand that refusal to grant consent will not jeopardize my right to obtain treatment except where disclosure is necessary for treatment. Consent may be withdrawn at any time by putting that request into writing to the Chiropractic Health Center of Bristol. Withdrawal of consent shall in no way affect communications or records disclosed prior to notice of such a withdrawal. I understand the reasonable benefits and disadvantages of my decision concerning release of information specified above. This release will expire seven years after the last dated entry into my medical records.

CHIROPRACTIC HEALTH CENTER OF BRISTOL, LLC

David M. Spitz, DC*
*** Board Eligible Chiropractic Neurology**

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Chiropractic Health Center of Bristol, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required or administrative purposes, and to evaluate the quality of care that you receive.

Chiropractic Health Center of Bristol, LLC will not disclose you information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Chiropractic Health Center of Bristol, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Chiropractic Health Center of Bristol, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of you health records.

You may complain to the Privacy Officer Lynn Popielarczyk and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Chiropractic Health Center of Bristol, LLC must maintain the privacy of protected health information, provide your with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Lynn Popielarczyk at 860-583-4346

____________________________________ ______________________
Patient Signature Date

Chiropractic Health Center of Bristol
22 Pine Street, Suite 216
Bristol, CT 06010
860-583-4346

FORM: Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by David M. Spitz, DC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of David M. Spitz, DC and any or all of their Associate Doctors of Chiropractic.

I understand that diagnosis or treatment of me by Chiropractic Health Center of Bristol, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Chiropractic Health Center of Bristol, LLC is not required to agree to the restrictions that I may request. However, if David M. Spitz, DC agrees to a restriction that I request, the restriction is binding on David M. Spitz, DC and Chiropractic Health Center of Bristol, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractic Health Center of Bristol LLC or David M. Spitz, DC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review David M. Spitz, DC, DC's Notice of Privacy Practices prior to signing this document.

Upon your request, The Chiropractic Health Center of Bristol, LLC Notice of Privacy Practices will be provided to you.

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 the [Health Care Provider].

The Notice of Privacy Practices for Chiropractic Health Center of Bristol, LLC is also provided 22 Pine street, Suite 216 - CT - Bristol - 06010 and on the Chiropractic Health Center of Bristol, LLC web-site, www.backdoc.com .

This Notice of Privacy Practices also describes my rights and the duties of Chiropractic Health Center of Bristol, LLC with respect to my protected health information.

David M. Spitz, DC 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 accessing the Chiropractic Health Center of Bristol, LLC web site, 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

Chiropractic Health Center of Bristol
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