Simmons Family Chiropractic, PLLC

**BASIC PATIENT INFORMATION:**

Dr. Mr. Mrs. Ms. (circle one)

First Name:_____ Middle Initial: __ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Cell Phone: ( ) _____-_____ E-mail address: _____

Date of Birth: _____ /_____ /_____ Sex: Male Female (circle one)

Social Security Number: _____ - ____ - _____ Marital Status: Single Married Other (circle one)

Employment Status: Employed Full-Time Student Part-Time Student Other (circle one)

**INSURANCE INFORMATION:**

Policy Holder: Self Spouse Other:_____ (circle one)

Policy Holder First Name:_____ Middle Initial: _____ Last Name:_____

Policy Holder Social Security Number: _____ - ____ - _____

Policy Holder Date of Birth: _____ /_____ /_____

Address (if different from yours):_____ City:_____ State: ___ Zip code: _____

**Spouse Data:**

Is your spouse a patient in the clinic? Yes No (circle one)

First Name:_____ Middle Initial: __ Last Name:_____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

**Employer Data:**

Employer:_____

Address:_____

City:_____ State:_____ Zip Code: _____
Phone Number: (  ) _____-_____

**Emergency Contact:**

Contact Name: _____

Contact Phone: _____

**Family Physician:**

Doctor Name: _____ Practice Name: _____

Phone Number: (  ) _____-_____ Date Last Seen: _____

**Treatment Authorization:**

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees, and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature:_____ Date: _____

**Consent to Treat a Minor:**

I (we) being the parents, guardian, or custodian of the minor being, _____, Age _____, do hereby authorize, request, and direct this office, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under the care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) authorize the doctor to release all information necessary to secure payment of benefits. I (we) authorize the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature:_____ Date: _____

Witness: _____ Date: _____

## Acknowledgement of Receipt:

As required by the Privacy Regulation, I hereby acknowledge that I have reviewed a current copy of the Notice of Privacy Practices of Simmons Family Chiropractic, PLLC.

I am aware that Simmons Family Chiropractic, PLLC has included a provision that it reserves the right to change the terms of this notice and to make the new provisions effective for all Protected Health Information that it maintains.

Patient's Name: _____

If signed by representative of the patients:

Representative's Name: _____

Relationship: _____

Patient's/Representative's Signature: _____ Date: _____

(Office Use Only)

Authorized Facility Signature: _____ Date: _____

Who may we thank for referring you to our office?

| | | | | |
|---|---|---|---|---|
| Family Member | Attorney | Brochure | Website | Health Fair |
| Friend | Newspaper Ad | Spinal Screening | Employer | Sign on building |
| Physician | Other: _____ | | | |

If you selected 'family member', 'friend', or 'physician,' please enter their name below:

_____

---

## MEDICAL CONDITIONS: (please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Arthritis | Cancer | Diabetes | Stroke | Menstrual Problems |
| Hypertension | Psychiatric Illness | Skin Disorder | Heart Disease | Depression |
| Fractured Bones | Dislocated Bones | Joint Replacement | Metal implants | Anxiety |
| Whiplash | Pacemaker | Herniated Disc | Pinched Nerves | Thyroid Disease |
| Scoliosis | Pulmonary Disease | High Blood Pressure | Stroke | Liver Problems |
| Aneurysm | Seizures | Osteoporosis | Tumors | Hearing Loss |
| Asthma | Ear Infections | Kidney Stones | High Cholesterol | Heart Disease/Heart Attack |
| High Cholesterol | Liver Disease | | | |

Other: _____

Height: _____ Weight: _____

Have you had a recent weight loss or weight gain? Y or N

Please list any surgeries/hospitalizations:

_____

_____

Please list any allergies:

_____

Please list current medications:

_____

_____

_____

What is your major complaint/reason you are seeking care?

_____
_____

**SOCIAL HISTORY:**

Do you consume caffeine? Y or N  Do you smoke? Y or N  Do you use tobacco? Y or N

Do you consume alcohol? Y or N  Do you exercise? Y or N

**FAMILY HISTORY:**

Arthritis  Cholesterol  Diabetes  Cancer  Heart Disease  Thyroid Disease

High Blood Pressure  Stroke  Psychiatric Illness  Other: _____

How many children do you have?_____

What are their ages?_____

**OCCUPATIONAL ACTIVITIES:**

| | | | |
|---|---|---|---|
| Administration | Business Owner | Clerical/Secretarial | Computer User |
| Construction | Childcare/Educator | Executive/Legal | Food Service Industry |
| Health Care | Heavy equipment | Manual Labor | Homemaker |