

New Patient Health History Form # _____

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone #'s Hm _____ Wk _____ Cell _____
Preferred method of contact: _____ Email _____ Text _____ Phone/Home/Work/Cell _____
Age _____ Birth date _____ SS # _____ Ref By _____
Occupation _____ Employer _____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's Health Status _____ Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* Work Other
Please describe _____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? No Yes If yes, when? _____
List other practioners seen for this injury/condition _____
Have you ever been under chiropractic care? No Yes
If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____
Do you have health insurance? No Yes Name of company _____
** If an auto accident please provide:*
Insurance company name _____ Contact person _____
Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes Height _____ Weight _____

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What gives relief of your symptoms?		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

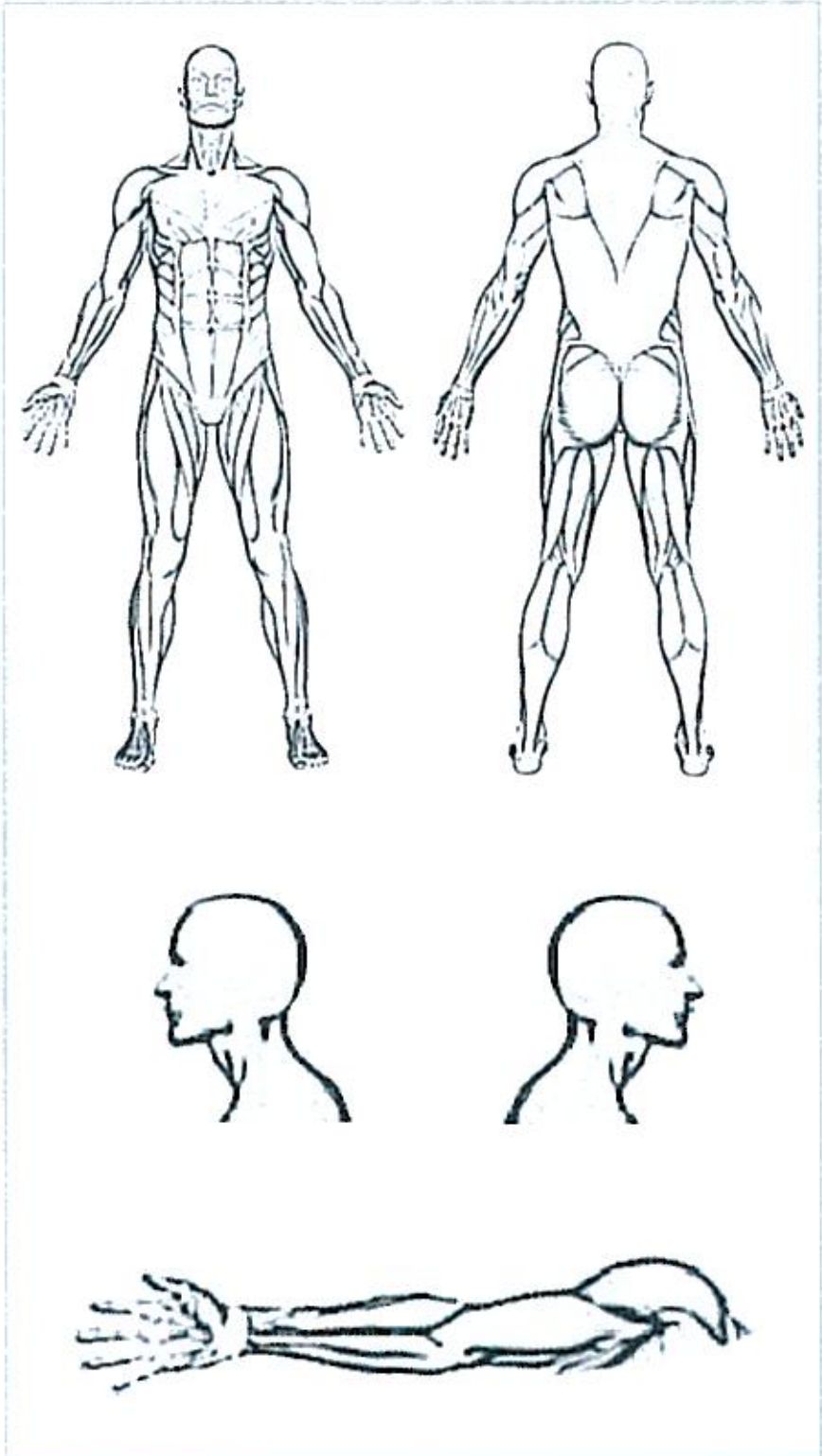
Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Veneral Disease
- Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A=Ache
- B=Burning
- N=Numbness
- O=Other
- P=Pins & Needles
- S=Stabbing



Medicare Initial History

Patient: _____ Date: _____ Chart # _____

Vitals: Ht: _____ Wt: _____ BP: _____ Pulse: _____

Chief Complaint (What is bothering you?):

Mechanism of Trauma (How did it happen?):

Onset (When did it start?): _____

Quality/Character (sharp, dull, ache): _____

Frequency/Duration (When and how long?):

Better/Worse: _____

Referral/Other Symptoms: _____

Previous Occurrences: _____

Secondary Complaints: _____.

Previous Care: _____.

Relative Contraindications:

Do you have any of the following conditions?

- Joint Hypermobility
- Osteoporosis/Osteopenia
- Benign Bone Tumors
- Bleeding Disorders
- Blood Thinners
- Progressive Radiculopathy

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **may be contraindicated** in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.

Absolute Contraindications:

Do you have any of the following conditions?

- Rheumatoid Arthritis
- Ankylosing Spondylitis
- Ligament Laxity
- Joint Dislocation
- Recent/Unstable Joints
- Unstable/Missing Dens at C2
- Spinal Cancer
- Spinal/Joint Infection
- Myelopathy/Cauda Equina Syndrome
- Vertebrobasilar Insufficiency Syndrome
- Arterial Aneurysm

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **is absolutely contraindicated** in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.

Medications/Vitamins: _____.

Spinal injuries: _____.

Surgeries: _____.

Hospitalizations: _____.

Last Examination: _____.

Previous Chiropractic Care: _____.

Other History: _____.

Relevant Family History: _____.

Diet: _____.

Exercise: _____.

Occupation/Recreation: _____.

Remarks: _____.

History Taken By: _____.

Reviewed By Doctor: _____.

Notes:

_____.

Raveling Chiropractic Center 1116 Belcher Road Dunedin FL 34698

Notice Of Non-Coverage For Medicare Services

Raveling Chiropractic Center

It is important that you understand that Medicare does NOT pay for all chiropractic services. Medicare only pays for chiropractic care that they consider medically reasonable and necessary.

Medicare will not pay for certain services in this office, including but not limited to:

1. Initial or Re-exams;
2. X-rays;
3. Physical Therapy;
4. Nutritional Supplements;
5. Any tests performed in our office;
6. Maintenance care.

Payment of services:

You will be required to pay the balance of your yearly deductible, co-payment and 100% of all non-covered services. Supplemental insurance may cover services that Medicare does not cover. If you are unable to pay any portion of your deductible or co-payments, please let us know immediately so that we can work out financial arrangements out with you.

Patient Name

Chart #

Patient Signature

Date

Raveling Chiropractic Center

Dr. Paul A. Raveling, D.C., P.A.
1116 Belcher Road
Dunedin, Florida 34698

Telephone
(727) 733-0433
Fax
(727) 738-6187

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Raveling Chiropractic Center to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 727-733-0433. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____

Print Patient's Name

X _____

Patient's Signature

X _____ X _____

Other Than Patient, Print Name & Relationship

Witness

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____

Address: _____

Date of Birth: _____ **Date of Request:** _____

As required by the **Privacy Regulations**, this practice may not use or disclose your protected health information except as provided in our **Notice of Privacy Practices** without your authorization.

I hereby authorize this office and any of its employees to use or disclose my **Patient Health Information** to the following person(s), entity(s), or business associates:

Patient Health Information authorized to be **disclosed**:

For the specific purpose of (describe in detail)

Effective Dates for this authorization ____/____/____ through ____/____/____

This authorization will expire at the end of the above period.

(You may leave dates blank if authorization to the person(s) named above is for **the entire length of your treatment**)

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not have any effect on disclosures prior to the executions.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization if needed.
5. Restrict what is disclosed with this authorization.

(Signature of Patient/Guardian)

(Date)

(Authorized Signature of Facility)

(Date)