

# PATIENT INTRODUCTION CARD

No: \_\_\_\_\_

Date: \_\_\_\_\_

Name ( Mr. Mrs. Miss Ms.): \_\_\_\_\_ Phone: (Home): \_\_\_\_\_

Address: \_\_\_\_\_ Cell# \_\_\_\_\_

(Street, City, State, Zip Code)

Married \_\_\_ Single \_\_\_ Other \_\_\_ E-Mail (for Newsletter) \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ SS # \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone (Office) \_\_\_\_\_

Previous Chiropractic Care: \_\_\_ Yes \_\_\_ No Doctor's Name: \_\_\_\_\_

Name of your insurance company: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Major Complaint \_\_\_\_\_

Who (or what Source) referred you? \_\_\_\_\_

**It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged**

# PATIENT PERSONAL/CONFIDENTIAL DATA

No. \_\_\_\_\_ Date \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Spouse \_\_\_\_\_ SS No.: \_\_\_\_\_ No. of Children: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

How did you learn of this clinic? \_\_\_\_\_

Nearest relative not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_

Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_

## PATIENT'S INSURANCE

## SPOUSE'S INSURANCE

Name of Company: \_\_\_\_\_ Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

ID & Group No.: \_\_\_\_\_ ID & Group No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Purpose of this appointment and list your complaints: \_\_\_\_\_

Date of illness: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_

How did accident occur?  Auto  On the job  Other, \_\_\_\_\_

Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_

Other Doctor seen for this condition: \_\_\_\_\_

Have you been treated by a Doctor for any health condition in the last year?  Yes  No

If yes, please describe: \_\_\_\_\_

## INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature Physician: \_\_\_\_\_ Signature Patient: \_\_\_\_\_

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: \_\_\_\_\_

Parent's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
 No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

**ARE YOU PREGNANT?**  
 YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

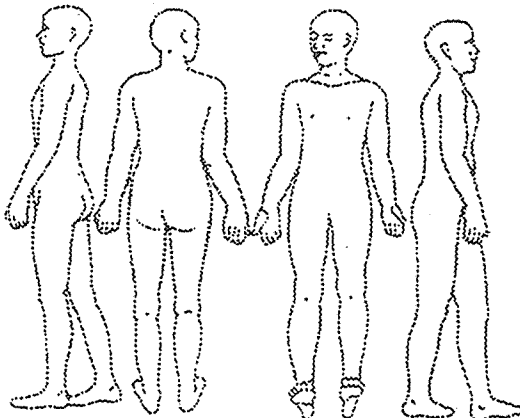
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- \_\_\_\_\_

## SYMPTOM LOCALIZATION



P \_\_\_ Pain  
 N \_\_\_ Numb  
 S \_\_\_ Spasm  
 T \_\_\_ Tender  
 H \_\_\_ Hypoesthesia

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE .....

Patient Accepted?  Yes  No Doctor's Signature \_\_\_\_\_



TERESA HAZELWOOD, D.C.

77 Charleston Square  
Saint Charles, MO 63304  
Telephone: (636) 939-3990  
Fax: (636) 939-3909

## 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. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

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Name of Patient

Date