Complete Chiropractic
NEW PATIENT INFORMATION
(PLEASE FILL IN ALL PERTINENT INFORMATION ASSOCIATED WITH YOUR SITUATION)

PERSONAL INFORMATION

ARE YOU HERE FOR - ☐ WEIGHT LOSS OR ☐ QUITTING SMOKING

Date:_____

Last Name:_____ First Name:_____ MI:_____

Street:_____ E-Mail Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____ Pager:_____

Date of Birth:_____ Current Age:_____

Sex: ❑ Male ❑ Female Employment: ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Student

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced Number of Children:_____

Occupation:_____

Spouse's Name:_____ Primary Care Physician's Name:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred By:_____

❑ Family Member ❑ Friend ❑ Co-worker ❑ Attorney ❑ Family Physician

❑ Yellow Pages ❑ TV Commercial ❑ Newspaper ❑ Radio ❑ Billboard ❑ Street Sign Other:_____

HEALTH HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Neck Pain
Back Pain
Arm Pain
Leg Pain
Degenerative Disc Disease
Herniated Disc
Headaches
Osteoporosis
Arthritis
Rheumatoid Arthritis
Pinched Nerve

AIDS/HIV
Allergies _____
Bleeding Disorders
Cancer
Chemical Dependency
Depression
Emphysema
Epilepsy
Heart Disease
Hepatitis
Multiple Sclerosis

Pacemaker
Psychiatric Care
Tuberculosis
Stroke
Diabetes

Other _____

What medications are you currently taking?

_____

_____

Signature of Responsible party (Patient or Parent) _____Date: _____

Complete Chiropractic

1536 Jeffco Blvd
Arnold, MO 63010
636-287-2200

HIPPA Privacy Statement

For use and/or disclosure of Protected Health Information (PHI) To carry out treatment, payment and healthcare operations

By signing this Consent, I acknowledge and agree to the following:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry ou the healthcare operations. The Practice explained to me that the Privacy Notice would be available to me at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice, in accordance with applicable law.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is provided on the wall in the waiting area. I may also request a copy from this office at any time.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

5. If a patient or acquaintance comes into the facility and asks about you by name (friend, relative or referral) we will only give general information about your condition.

6. Please be advised that conversations may be overheard by others in our facility. A private room will be provided to discuss any personal conditions, treatment options or concerns you may have

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) **Signature of Individual**

PATIENT CONSENT AUTHORIZATION

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).

I hereby have been informed of the potential risk of auriculotherapy ear stapling and give my complete consent to the treatment. I have also been informed of the time frame of after care for this procedure and will follow those instructions given by the physician. I also hereby state that I am not pregnant or in my first trimester of pregnancy.

_____
Print Patient's Name

_____ _____
Patient's Signature Date

_____ _____
Witness Date