CONFIDENTIAL PATIENT INFORMATION

Please answer ALL the questions in detail to the best of your ability. *(All information you give is confidential)*

PERSONAL INFORMATION

Today's Date: ___________________________

Name:__________________________________ ☐*Female* ☐*Male* Social Security No.________/_______/_________

(for insurance verification purposes)

Address: ____ City:______________________ State:_________ Zip:__________

Home No. (____)__________________ Cell No. (_____)___________________ Work No. (____) ___________________

Date of Birth: .________/________/__________ Age:__________ Height: _____ft _______in Weight:_____________

☐ *Minor* ☐*Single* ☐*Married* ☐*Separated* ☐*Divorced* ☐*Widowed* ☐Partnered for ____ years Name of Spouse: ________________________

Number of children________Name:_____________ age:_____ / Name:_____________ age:_____ / Name:_____________age:_____

/ Name:_____________ age:_____ / Name:_____________ age:_____ / Name:_____________ age:_____

Occupation:____ Employed by:____

Complete e-mail address: ____@ ______________________________ . ________

Have you ever been to a chiropractor before? ☐*Yes* ☐*No* *If yes*, when? ____________________________________

Whom may we thank for referring you? ☐*Dex Yellow Pages* ☐ *Online* ☐*Yellow Book* ☐*Health Insurance* ☐*Walk-by* ☐*Banner* ☐*Expo*

☐ *Talk/Screening by Dr. Mitch Borst* ☐Other __________________ ☐ *Friend (please give name so we can thank them with a gift!)*___________ ________

IN CASE IF EMERGENCY, CONTACT

Name____ Relationship ____

Home No. (____)__________________ Cell No. (_____)___________________ Work No. (____) ___________________

CURRENT HEALTH CONDITION

Please list your current complaints in order of pain severity: ***(please circle one)***

(main complaint)_________________________________ How long have you had this problem? #_________ years / months/ days

(2nd complaint)_________________________________ How long have you had this problem? #_________ years / months/ days

(3rd complaint)_________________________________ How long have you had this problem? #_________ years / months/ days

Are you having any problems with the following? ☐ Jaw ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Rib Cage

☐ Pelvis ☐ Thigh ☐ Hip ☐ Knee ☐ Lower Leg ☐ Ankle ☐Foot

Have you consulted another doctor for these conditions? ☐*Yes* ☐*No* *If yes, when?* ______________________________

Other Doctors / Professionals seen for these conditions: ____

Have you had similar conditions to these before? ☐*Yes* ☐*No* *If yes, when?* ________________________________

Are any of these conditions… ☐*Job Related* ☐*Auto Accident* ☐*Home Injury* ☐*Falling* ☐*Other*______________________

If Job related, have you made a report of your accident to your employer? ☐*Yes* ☐*No* ☐*N/A*

Does your condition ☐*Come and Go* **or is it** ☐*Constant* ? How did it start? ☐*Gradually* ☐*Suddenly*

What makes it feel ***better***? ☐*Rest* ☐*Heat/Ice* ☐*Lying* ☐*Chiropractic Adjustment* ☐*Massage* ☐*Standing* ☐*Sitting* ☐*Other*__________

What makes it feel ***worse***? ☐*Stress* ☐*Activity* ☐*Lifting* ☐*Standing* ☐*Sitting* ☐*Bending* ☐*Work* ☐*Turning* ☐*Other*____________

How would ***describe*** the pain? ☐*Sharp* ☐*Dull* ☐*Achy* ☐*Burning* ☐*Stabbing* ☐*Deep* ☐*Shooting* ☐*Other*___________________

Have you lost any days at work because of this condition? ☐*Yes* ☐*No* If yes, *how many?* ___________________________

On the scale below, please circle the severity of your main complaint (*at it's worst*)

None *Slight* *Mild* *Moderate* *Severe*

1	2	3	4	5	6	7	8	9	10

On the scale below, please circle the percentage of time you experience your main complaint (*at its worst*)

None *Occasional* *Intermittent* *Frequent* *Constant*

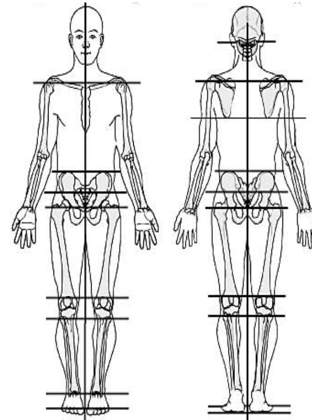
10	20	30	40	50	60	70	80	90	100

On the diagram below, please circle where you are experiencing ALL of your present complaints using the following letters:

Do you have pain and/or difficulty performing any of the following activities (please check✓). **If none put a big N/A in the middle**

_____personal care	_____lifting
_____reading	_____concentrating
_____work	_____driving
_____sleeping	_____recreation
_____walking	_____sitting
_____standing	_____social life

IMPORTANT…Please fill out! Circle where you hurt and put the letter of how you feel next to it.



A: ache
B: burning pain
C: cramping
D: dull pain
N: numbness
R: throbbing pain
T: tingling
O: other_________

____

____

PAST HISTORY

What operations have you had? ____

Illness Current or Past? ____

Broken / Fractured Bones? ☐*Yes* ☐*No* *Which ones?* ______________________________

Have you ever been hospitalized? ☐*Yes* ☐*No* *If yes, why?* ______________________________

Medical Doctor ______________________ Date of last visit _________________ Purpose ______________________

Females: Are you pregnant? ☐*Yes* ☐*No* ☐*Unsure*

List any medication/drugs you are currently taking (both prescription and non-prescription):____________________________

____

PLEASE 'X' ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 12 MONTHS

☐ Auto accidents
___ 0-1 year ago;
___ 1-5 years ago;
___ 5 years or more.
☐ Other accidents / falls
☐ Arthritis
☐ Convulsions, epilepsy
☐ Cancer
☐ Frequent colds/flu
☐ Depressed
☐ Anemia

☐ Allergy/sinus
☐ Stress
☐ Eating disorders
☐ Trouble sleeping
☐ Trouble concentrating
☐ Learning disability
☐ Mood changes
☐ Ringing in ears
___Right side ___Left side
☐ Pain when you cough or sneeze
☐ Headaches
☐ Chest pain / asthma

☐ Stroke
☐ Varicose veins
☐ Liver trouble
☐ Gall bladder trouble
☐ Hemorrhoids
☐ Impotence
☐ Kidney trouble
☐ Bedwetting
☐ AIDS, HIV

Exercise	Work Activity	Habits	
☐None	☐Sitting	☐Smoking	Packs/Day _______________
☐Moderate	☐Standing	☐Alcohol	Drinks/Week _______________
☐Daily	☐Light Labor	☐Coffee/Caffeine Drinks	Cups/Day_______________
☐Heavy	☐Heavy Labor	☐High Stress Level	Reason _______________

BILLING

Who is responsible for this account? YOU and… ☐Cash ☐Workers Comp ☐Auto Injury ☐Medicare ☐Personal Health Insurance ☐Parent

Primary Health Insurance Information (you do not need to fill this out if we make a copy of your insurance card.)

Insurance Company Name_________________________________ Member Services Phone # (   )___________-_________________

Policy #_____________________________________Group# ________________________ Name of Insured __________________________

**Is Patient covered by additional insurance? ☐*Yes* ☐*No* *If yes, please fill-out the following information.*

Secondary Health Insurance Information (you do not need to fill this out if we make a copy of both of your insurance cards.)

Insurance Company Name_________________________________ Member Services Phone # (   )___________-_________________

Policy #_____________________________________Group# ________________________ Name of Insured __________________________

If someone else other than patient please fill out the following:

Name:____________________________________ ☐*Female* ☐*Male* Social Security No._________/________/__________

Date of Birth: ._________/________/__________

Address: ____ City:______________________ State:_________ Zip:____________

Home No. (____)__________________ Cell No. (_____)____________________ Work No. (____) _____________________

PAYMENT IS EXPECTED AT TIME OF VISIT

ASSIGN AND RELEASE & CONSENT FOR TREATMENT

I certify that if I, and/or my dependent(s), have insurance coverage I assign directly to Dr. Mitchell Borst and , all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions.

Dr. Mitch Borst and may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services.

I, the undersigned, a patient in this office, hereby authorize/consent Dr. Mitchell Borst, DC, , Ancala Chiropractic, Desert Ridge Chiropractic, New Beginnings Chiropractic, their associates or interns (and whomever he may designate as his assistant(s) to administrator treatment as necessary). I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I also authorize Dr. Mitchell Borst and to give chiropractic in an “open-door”, adjusting environment, and can use my name on welcome boards, referral boards, sign-in sheets, and travel file use. I understand it is the desire of this office to provide chiropractic care in an “open-door” adjusting environment. An open-door approach involves the doctor moving from patient-care area to patient-care area. As a result, patients and patient files with patient names are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examination of present reports and findings. These procedures are completed in a private, confidential setting. I also understand e-mail address will not be sold to anyone but used only from their office for their newsletter, office news or contact purposes. I also authorize this office to pre-approve me for payment arrangements through CareCredit® by the use of my name and address only, which will *not* affect my credit report or credit score.

I also understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and payable to Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic. If my account goes to collections I am responsible for any and all collection fees. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic to do whatever is necessary in accordance with this state’s statues, to provide me with chiropractic care.

Patient’s Signature: ____ Date: ________________________

Guardian or Parent’s Signature: ____________________________________ Date: ________________________

HIPAA NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic 's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at 11259 E Via Linda, suite 108, Scottsdale, Arizona 85259. You may also send a written complaint to the US Department of Health and Human Services. For further information on Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's health information practices or if you have a complaint, please contact the following person:

HIPAA PATIENT INFORMATION CONSENT FORM

I have read and fully understand Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's Notice of Information Practices. I understand that Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name

____
Signature

____
Date