COASTAL CHIROPRACTIC

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Phone (302) 933-0700 Fax (302) 933-0800

New Patient Information:

Full name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____
Gender: ___Male ___Female
Marital Status: ___Single ___Married ___Other: _____
Primary Care Doctor: _____Phone:_____
Emergency Contact: _____Phone:_____
How did you hear about our office? _____

Patient Employer Data:

Employment Status:
__Employed ___Full time ___Part time ___Retired ___Unemployed ___Homemaker

Employer Name: _____
Job title/Position: _____

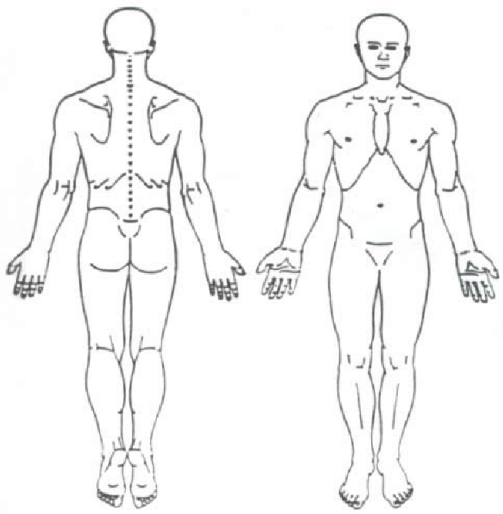
Health Insurance Information:

Primary Health Insurance: _____
Address: _____
Phone: _____
Member/Subscriber ID#: _____
Does your insurance plan require prior authorization for specialist visits? _____

Secondary Health Insurance: _____
Address: _____
Phone: _____
Member/Subscriber ID#: _____

Patient Symptoms:

Please mark where your pain/symptoms are:



Please grade your pain on a scale of 0-10: Check how frequent the pain is present:
(0=NO PAIN, 10=EXTREME PAIN)

NECK:	0 1 2 3 4 5 6 7 8 9 10	Seldom-Intermittent-Frequent-Constant
Upper/Mid Back:	0 1 2 3 4 5 6 7 8 9 10	Seldom-Intermittent-Frequent-Constant
Lower Back:	0 1 2 3 4 5 6 7 8 9 10	Seldom-Intermittent-Frequent-Constant

When did your symptoms appear? _____
Is the condition getting progressively worse? _____

Type of pain:

___SHARP ___DULL ___THROBBING ___NUMBNESS ___ACHING ___SHOOTING
___BURNING ___TINGLING ___CRAMPING ___STIFNESS ___SWELLING ___OTHER

Does it interfere with ___SLEEP ___DAILY ROUTINE ___RECREATION?

Activities that are painful to perform:
___SITTING ___STANDING ___WALKING ___BENDING ___LYING DOWN
___OTHER _____

Have you ever had an X-ray, MRI or CT scan? If so, when and where?

_____

What treatments have you already received for your condition?
___ MEDICATIONS ___PHYSICAL THERAPY ___SURGERY
Name of other doctors that have treated you for your condition:

_____Phone:_____

Last Chiropractic exam/treatment: _____

Health History:

Please check any of the following that you have or have had:

___AIDS/HIV	___Glaucoma	___Pacemaker	___Alcoholism	___Goiter	___Parkinson's Disease
___Allergy Shots	___Lupus	___Pinched nerve	___Anemia	___Gout	___Hepatitis
___Pneumonia	___Anorexia	___Heart Disease	___Polio	___Appendicitis	___Herniated Disc
___Prostate Problem	___Arthritis	___Hernia	___Prosthesis	___Asthma	___High Blood Pressure
___Psychiatric Care	___Bleeding disorder	___Herpes	___Rheumatoid Arthritis	___Breast Lump	___Kidney Disease
___Rheumatic Fever	___Bronchitis	___High Cholesterol	___Scarlet Fever	___Bulimia	___Measles
___STD	___Cancer	___Liver Disease	___Stroke	___Cataracts	___Miscarriage
___Suicide Attempt	___Migraines	___Thyroid Problems	___Fibromyalgia	___Chicken Pox	___Multiple Sclerosis
___Tonsillitis	___Diabetes	___Mononucleosis	___Tuberculosis	___Emphysema	___Osteoporosis
___Tumors, Growths	___Epilepsy	___Mumps	___Typhoid Fever	___Fractures	
___Ulcers	___Anxiety	___Depression	___Bipolar Disorder	___Shingles	

Other: _____

Are you pregnant? ___Yes ___No ____ Not Sure ____ Due Date _____

Exercise:
____None ____Occasionally ____Daily ____Heavy

Work Activity:
___ Sitting ___Standing ___Light Labor ___Heavy Labor

Habits:
___Smoking; Packs/Day___ _____Alcohol; Drinks/Week _____
Coffee/caffeine drinks Cups/Day _____

Previous injuries: Please include description and dates

Falls: _____
Head Injuries: _____
Broken Bones: _____
Dislocations: _____
Surgeries: _____

Medications:_____
_____
_____

Family History:
Please describe any relevant, immediate family history, e.g. cancer, diabetes, heart disease, etc.
_____
_____

COASTAL CHIROPRACTIC, LLC

INSURANCE AUTHORIZATION FORM

PATIENT NAME_____

RELEASE OF INFORMATION

I HEREBY AUTHORIZE COASTAL CHIROPRACTIC, LLC TO RELEASE MEDICAL AND FINANCIAL DATA TO MY INSURANCE CARRIERS, OTHER MEDICAL FACILITIES AND ATTORNEY(S).

RESPONSIBILITY OF BILL

THE UNDERSIGNED HEREBY ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR CHARGES AND SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE.

THE UNDERSIGNED UNDERSTANDS THAT SERVICES ARE RENDERED AND CHARGED TO YOU (THE PATIENT) AND NOT TO YOUR INSURANCE COMPANY. COASTAL CHIROPRACTIC, LLC DOES NOT ACCEPT RESPONSIBILITY FOR COLLECTING AN INSURANCE CLAIM OR NEGOTIATING A DISPUTED SETTLEMENT. IT IS THE FINANCIAL OBLIGATION OF THE UNDERSIGNED TO BE RESPONSIBLE FOR ANY CHARGES OR SERVICES NOT COVERED BY INSURANCE FOR WHICH PAYMENT IS DENIED THROUGH ANY UTILIZATION REVIEW OR PRE-CERTIFICATION PROCEDURES, OR ANY REMAINING BALANCE UPON COMPLETION OF A SETTLEMENT. THE UNDERSIGNED ALSO AGREES THAT THIS OBLIGATION SHALL EXIST REGARDLESS OF PRIVATE CONTRACTUAL AGREEMENT BETWEEN THE PATIENT AND ANY INSURANCE CARRIER, ATTORNEY OR THIRD PARTY NOT SIGNING THIS AGREEMENT.

CONSENT FOR TREATMENT OF A MINOR CHILD

CONSENT IS HEREBY GIVEN BY THE UNDERSINGED FOR CHIROPRACTIC TREATMENT, X-RAYS AND DIAGNOSTIC STUDIES AS ORDERED BY THE DOCTORS AND THERAPIES (THERAPEUTIC MASSAGE, ELECTRICAL STIMULATION, ICE/HEAT THERAPY, HYDROTHERAPY, THERAPEUTIC EXERCISES) PERFORMED BY THE TECHNICAL STAFF OF COASTAL CHIROPRACTIC, LLC. THE UNDERSIGNED STATES THAT HE/SHE IS THE PATIENT'S LEGAL GUARDIAN**.**

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I HEREBY IRREVOCABLY AUTHORIZE PAYMENT OF MY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME TO BE MADE PAYABLE AND MAILED DIRECTLY TO COASTAL CHIROPRACTIC, LLC FOR PROFESSIONAL SERVICES RENDERED. NO OTHER THIRD PARTY, INCLUDING MY ATTORNEY, SHOULD RECEIVE PAYMENT OF MY BILLS EXCEPT THIS OFFICE FOR THE REMAINDER OF THIS CLAIM. IT WILL BE ASSUMED AND RELIED UPON THAT THE INSURANCE CARRIER HAS AGREED TO AND ACKNOWLEDGED MEDICAL COVERAGE AND WILL SEND PAYMENT DIRECTLY TO THIS OFFICE.

_____

PATIENT OR GUARDIAN'S SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**

COASTAL CHIROPRACTIC HIPAA COMPLIANCE/PATIENT CONSENT FORM

Patient Name_____

Notice of our privacy practices provides information about how we may use or disclose protected health information about you. This notice contains a patient's rights describing your rights under the law.

You have the right to restrict how your protected health information is disclosed for treatment, payment or other healthcare operations.

Authorization is voluntary and you may change or revoke this consent in writing, signed by you, however, if you do revoke the authorization, it will not have any effect on any actions taken by Coastal Chiropractic, LLC prior to the receipt of the revocation.

Please answer each question to the protected health information that may be used or disclosed on your behalf for treatment, payment or other healthcare operations.

May we disclose medical records to primary care physician or referring physician?
YES NO

May we disclose information about your diagnosis, treatment and services you received to your healthcare insurance for purposes of reimbursement for services rendered?
YES NO

May we phone or send a text message to confirm or update you about an appointment?
YES NO

May we leave a message on your answering machine at home or cell phone?
YES NO

May we discuss your medical condition with any member of your family?
YES NO

_____ _____

Signature of patient or representative Date