

Patient Information

Last _____ First _____ Date of Birth _____ Age _____

Address _____
Street or PO Box _____ City State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Social Security # _____ Ethnicity _____ Sex: **M / F** Marital Status: **S M D W**

Employer _____ Occupation _____ Work Phone _____

Spouse Name _____ Employer _____ Work Phone _____

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Parent name _____ Cell Phone _____ Alternate Phone _____

Parent name _____ Cell Phone _____ Alternate Phone _____

Responsible Party _____ Birth Date _____ SSN _____

Address if Different _____
Street or PO Box _____ City State _____ Zip Code _____

INSURANCE INFORMATION*****PLEASE PROVIDE CARD SO THAT WE MAY MAKE A COPY*****

Insurance #1 _____ Name of Insured _____

Relationship to Patient _____ Birth Date _____ SSN _____

Insurance #2 _____ Name of Insured _____

Relationship to Patient _____ Birth Date _____ SSN _____

If over 18 can we contact your parent listed above to discuss financial information? _____ **YES** _____ **NO**

Is this an accident that occurred during school sports? **YES / NO** if yes, Date _____

Have you been injured on the job? **YES / NO** If yes, Date _____ If yes, who is your employer? _____

If accident, is there an attorney involved? **YES / NO** If yes, attorney name _____

Is this condition a pre-existing condition or a medical condition existing at a time when new insurance is applied for, for which treatment is not covered by the insurance? **YES or NO**

In case of emergency, please notify _____ Relationship _____ Phone # _____

Who referred you to this practice? _____ Primary Care Provider _____

Assignment of Insurance Benefits

I hereby authorize assignment of my medical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my Chiropractor, **Timothy Melton, DC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature of Patient _____ (If less than 18 years of age Parent/Legal Guardian) _____ Date _____

Staff Initial _____

Tim Melton, DC
4351 Ridgemont Drive Suite A
Abilene, TX 79605

AUTHORIZATION FOR CHIROPRACTIC CARE

I, the undersigned, a patient in this office, hereby authorize Dr. Tim Melton to administer such treatment as is necessary, and to perform therapy and adjustment and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand that AUTHORIZATION FOR CHIROPRACTIC CARE, the reason why the above treatment is considered necessary, its advantages and possible complication, if any, as well as possible alternative modes of treatment, which was explained to me by Dr. Melton.

I certify that no guarantee of assurances have been made as the results that may be obtained.

Patient Signature _____

Date _____

***** I ALSO UNDERSTAND THAT ANY CARE RENDERED AFTER NORMAL BUSINESS HOURS WILL HAVE AN ADDITIONAL FEE THAT IS NOT COVERED UNDER MEDICARE, WORK COMP OR OTHER HEALTH PLANS. THE INDIVIDUAL IS ULTIMATELY RESPONSIBLE FOR THIS ADDITIONAL FEE. *****

Release of Protected Health Information HIPPA
My Protected Health Information may be released to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***If you would like anyone other than yourself to be able to call our office and to discuss your account or medical information you must print his/her name in the space provided. This does include spouses.**

***If patient is a student athlete, can private health care information be discussed with the school's certified athletic trainer? YES or NO**

In order to ensure that you receive comprehensive and quality healthcare, do you consent to have your medical records sent to any of your **primary care doctors or specialists on record?** YES or NO

I hereby authorize my physician Tim Melton, DC to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the **insurance, Medicare, or any other health plan or its agents**, any information needed to determine these benefits or the benefits payable to related services. YES or NO

X _____
Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

I have reviewed this office's Notice of Privacy Practices from Tim Melton, DC, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

X _____
Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial _____

Tim Melton, DC

Chiropractic First Visit & Medical History

Name _____ Date _____

Age _____ Height _____ Weight _____

Reason for visit? _____

When did it your symptoms appear? _____

Is this condition getting progressively worse? YES: _____ NO: _____ Unknown: _____

Rate the Severity of your pain: **Pain Scale:** 0 1 2 3 4 5 6 7 8 9 10
(No pain) (Worst pain)

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling

Other?: _____

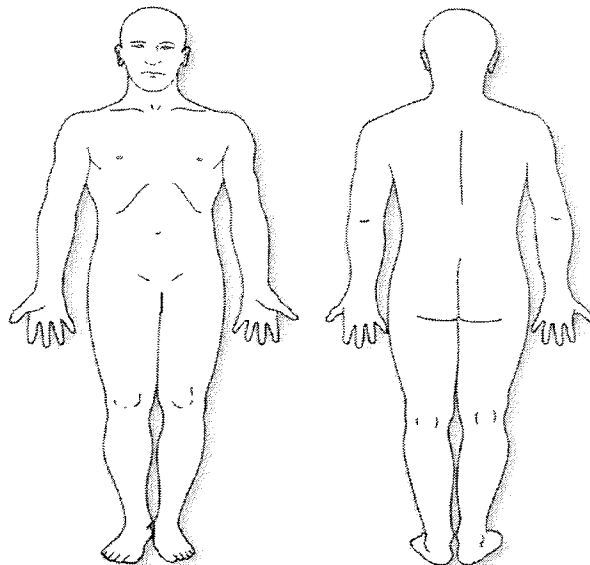
How often do you have this pain? _____

Is the pain constant in nature or does it come and go? _____

Does it interfere with your?: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark on the diagram where you are having the following symptoms:
Pain: XXX Numbness: OOO Tingling: ////



Medical History Form

Name: _____ Age: _____ Date of Birth: _____

What pharmacy do you use to fill medications?

Medications and dosages:

_____	_____	_____
_____	_____	_____

Allergies/Reactions:

_____	_____	_____
_____	_____	_____

Past Medical History

Do you have or have you had any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Diabetes
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Gout
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Depression	Anxiety	Thyroid Problems
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other: _____

Surgical History

Have you had any of the following surgical procedures? (Please circle and include dates)

Back Surgery _____
Neck Surgery _____
Knee Surgery _____
Shoulder Surgery _____
Heart Surgery _____

Other: _____

Family History

Does anyone in your family suffer from any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Diabetes
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Gout
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Arthritis	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Thyroid Problems
Arthritis	Rheumatoid Arthritis	Headaches	Psychiatric disorder

Other: _____

Social History

Are you: Married Single Divorced Widowed

Do you smoke? YES or NO Packs per day _____

Do you drink alcohol? YES or NO Drinks per week _____

Are you working? YES or NO Job Description: _____

Are you on restrictions? Yes or NO