

PROUGH CHIROPRACTIC
3402 Washington Rd., Suite 201
McMurray, PA 15317
PATIENT INFORMATION & CONDITION FORM

Today's Date: ___/___/___

Patient Name: _____ Birth Date: ___/___/___ Age: ___ Gender: F M

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____ Cell Phone (____) _____ E Mail Address _____

If you are under 18 years of age, who are your legal parents or guardians? _____

Marital Status: Single Married Separated Widowed How many children? _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ FULL-TIME PART-TIME

How did you learn about us or who referred you to us? _____

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

Describe the conditions, symptoms or purpose of the appointment: _____

Is your condition or injury due to an accident or work-related cause? YES NO

Did the condition or injury result from *automobile* accident? YES NO

Additional Information Related to the Condition:

Describe your pain: Sharp Stabbing Dull Ache Burning Tingling Numbness Burning Stiffness

What caused it? How did it happen?

What aggravates or makes it worse?

What relieves or makes it better?

Have you ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When/What date? ___/___/___

Describe:

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: __/__/____
Name: _____ Type of Practice: _____ Date of Last Visit: __/__/____
Name: _____ Type of Practice: _____ Date of Last Visit: __/__/____

Have you missed work or school due to your injuries? Yes No

Please check any of the following symptoms you are now experiencing:

- Headache Dizziness Thyroid Diarrhea Constipation
- Neck Pain/Stiffness Loss of Memory Stroke Seizures Nausea
- Pain/tingling in arms/hands Ears Ring/Buzz Hands Cold/Feet Ulcer Anemia
- Numbness in arms/hands Arthritis Diabetes Asthma Hernia
- Chest pain/rib pain Nervousness Heart Condition Loss of Balance Cold Sweats
- Pain/tingling in legs/feet Shortness of Breath High Blood Pressure Fever Fatigue
- Loss of arm/leg strength Loss of Smell Prostate Kidney Disorder Cancer
- Numbness in legs/feet Back Pain Burning muscle pain Difficulty swallowing

Other _____

What surgeries have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

What prescription medications are you currently taking?

Medication Allergies (please list all - medication and other):

Do you smoke? NO Former Smoker Yes - # of packs/day: _____ Do you drink alcohol? NO YES

HEIGHT : _____ WEIGHT: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

Do you have health insurance? YES NO Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth __/__/____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- NOT between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: __/__/____

Patient Questionnaire – Work-Related Accident

Patient Name: _____

Today's Date: ___/___/___

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___

Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Work-Accident Specific Information:

Check all that apply:

- Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?
- Did the accident occur during your normal working hours?
- Did you report the accident to your Employer?
- Is your Employer covered by Workers' Compensation Insurance under state law?
- Has your Employer prepared an initial written report?
- Does the Employer's Report describe the condition or symptoms you are experiencing?
- Has a claim number been issued for this accident?
- Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

**PROUGH CHIROPRACTIC
3402 Washington Rd., Suite 201
McMurray, PA 15317**

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Prough Chiropractic

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signature of Patient/Guardian:

_____ Date: _____

Please print patient/guardian name and relationship: _____

**Prough Chiropractic
3402 Washington Rd., Suite 201
McMurray, PA 15317**

HIPPA AUTHORIZATION FORM

Information to be Used or Disclosed

This information covered by this authorization includes your registration, information and your medical records included but not limited to: diagnostic test & lab results, x-ray, MRI, CT findings as well as past and current clinical examination, treatment notes, charges appointment times and dates. The information will be disclosed to assist in the authorization and payment for services, to coordinate, pre-certify and authorize care.

Persons to Whom Information may be Disclosed

Information described above may be disclosed to: (Spouse, Children, Friend, Office Staff, etc.) Please include home, work, and cell numbers.

If we are unable to contact you or if there is an urgency or emergency, who may we contact?

Name of person(s) and relation to the patient: _____

The authorization remains effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Prough Chiropractic. You should contact the privacy officer to terminate this authorization.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization.

You may refuse to sign this authorization.

Signature of Patient/Guardian: _____ Date: _____

Please print patient/guardian name and relationship: _____

Authorization Revoked : Effective through ___/___/_____

Refusing Authorization

I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form.