



# McCandless Chiropractic & Body Works

DATE: \_\_\_\_\_

## PERSONAL INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Marital Status: Single Married Widowed

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Carrier: \_\_\_\_\_  Reminder Text

**Email address for educational info & clinic announcements:** \_\_\_\_\_

We maintain full confidentiality of this information

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Spouse's Name: \_\_\_\_\_

Children: 1 2 3 4 5 other \_\_\_\_\_ Ages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Who referred you to our clinic?** \_\_\_\_\_  
 Physician Friend Family Newspaper Radio Health Fair Health Talk

How did your unwanted condition occur?  
 chronic condition accident/fall sports injury work related auto accident sudden onset unknown other

What medication are you currently taking? \_\_\_\_\_

What vitamins/supplements (including brand) are you taking? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

List past surgeries: \_\_\_\_\_

List past hospitalization: \_\_\_\_\_

## WHAT TYPE OF CARE ARE YOU SEEKING?

- WELLNESS**  
Improving overall general health in the absence of acute symptoms.
- CORRECTIVE**  
Restoring underlying problems while improving symptoms and decreasing pain
- NUTRITIONAL THERAPY**  
Promoting optimal health through education, goal setting, supplement recommendations & active lifestyle
- MASSAGE THERAPY**  
Enhance function, aid in the healing process, and promote relaxation and well-being.

Please indicate if you have a history of any of the following:	
Allergies	Osteoporosis
Aortic Aneurysm	Rheumatoid Arthritis
Asthma	Seizures
Cancer	Stroke
Chest Pain	Tuberculosis
Diabetes	Recent Weight Loss
Dizziness	Abdominal Pain
Gout	Bowel Dysfunction
Hepatitis A B C	Fibromyalgia
HIV/AIDS	Prostate Problems
Kidney Disease	Recent Infection
Kidney Stone	Sleep Disturbance
Leg/Calf Pain	Sinus Trouble
Multiple Sclerosis	Thyroid Disease

CONFIDENTIAL

PATIENT INFORMATION

## Employment Information

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_ How long employed there? \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Billing Information

**Please check any and all insurance coverage that may be applicable in this case**

Who will be responsible for your bill? Self Spouse Parent-Guardian Other

\_\_\_ Major Medical \_\_\_ Worker's Compensation \_\_\_ Medicare \_\_\_ Auto Accident \_\_\_ Other

Name of insurance company \_\_\_\_\_

Name of insured (card holder) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insured's (card holder's) Social Security Number \_\_\_\_\_

We will make every effort to help you receive the maximum benefit from your insurance. However, **please remember that your insurance is a contract between you and the insurance company.** We urge you to contact your insurance company to find out *your* benefits. If this is a Worker's Compensation claim, we **must** have prior employer approval before treatment can begin.

## Privacy Information

The patient understands and agrees to allow this clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

**AUTHORIZATION & RELEASE:** I authorize payment of insurance benefits directly to the doctor(s) or the clinic office. I authorize the doctor(s) and their staff to release all information necessary to communicate with other physicians and healthcare providers and payors and to secure the payment of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Furthermore, I understand that the records initiated by this clinic on my behalf are the permanent legal property of this clinic. I am entitled to a copy of the records for the prevailing fee.

I hereby give permission to the doctor(s) of McCandless Chiropractic to provide my MD/DO with periodic written and/or verbal updates regarding my health and treatment plan in order to coordinate the best possible care for me.

I authorize the office to discuss any aspects of my case (care, financial, etc.) with the following people:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Patient/Guardian Signature:

Date:

\_\_\_\_\_