THROM HEALTH AND WELLNESS

NEW PATIENT/PATIENT REACTIVATION FORM Date:_____

Demographic Information:

Name: _____ Preferred Name: _____ DOB: _____ Age: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Home Phone:_____

Employer: _____ Work Phone: _____

_____ Email:_____

Language:_____ Race:_____ Ethnicity: ____Hispanic ____Non-Hispanic

☐ Single ☐ Married ☐ Divorced ☐ Widowed No. of Children/Ages: _____

Spouse's/Children's Names:_____

Have you ever seen a chiropractor before? ☐ Yes ☐ No

If so, please list chiropractor(s), and recommendations below:_____

_____

_____

Reason for consulting our office:_____

Who referred you to our office? _____

Have you seen any health care provider(s) for your current condition? ☐ Yes ☐ No

If so, please list provider(s), and recommendations below:_____

_____

_____

Past Health History:

Do you have high blood pressure? Yes / No

Do you have diabetes? Yes / No

Are you a smoker? Yes / No

Surgery:_____

_____

Trauma:_____

_____

Illness:_____

_____

Medication/Supplements:_____

_____

Pregnancies:_____

Allergies: _____

_____

Family Health History:

Mother:_____

Father:_____

Maternal Grandparents:_____

_____

Paternal Grandparents:_____

_____

Siblings:_____

_____

Children:_____

_____

Other:_____

_____

Review of Systems: (Check all that apply)

____Eyes, Ears, Nose, Throat ____Blood Vascular ____Allergies ____Heart ____Lungs ____Stomach

____Hormones/Endocrine ____Internal Organs ____Urinary ____Skin ____Nerves ____Muscles

____Psychological Emotional ____Bones/Skeletal ____Joints ____Other:_____

Please give an explanation for any check marks:_____

_____

_____

Doctor Signature_____

THROM HEALTH AND WELLNESS

DOCTOR – PATIENT AGREEMENT

Privacy-

I acknowledge that I received, understand, and agree to the Notice of Privacy Practices of Throm Health and Wellness, which explains the policies and procedures of the clinic with regards to my Protected Health Information.

I AUTHORIZE _____TO HAVE ACCES TO MY CONFIDENTIAL RECORDS.
(someone other than yourself or Throm staff)

_____ Initials

_____ Individual's Phone Number

Consent for Treatment, Payment, and Healthcare Operations-

I consent to Throm Health and Wellness's use and disclosure of my Protected Health Information in order to provide treatment to me, for purposes relating to payment of services rendered to me, and for healthcare operations (quality assessment, credentialing, etc.). I agree that I am responsible for all bills incurred at this office. I authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand that my health and accident insurance policies are an arrangement between an insurance carrier and myself, however Throm Health and Wellness will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the clinic will be credited to my account upon receipt.

_____
Initials

Informed Consent to Chiropractic Care-

I acknowledge that I have been made aware of my condition, recommendations for chiropractic treatment and alternative treatment options, as well as the risks associated with chiropractic and other treatment options for my condition. I understand that chiropractic care focuses on the reduction/correction of subluxations in order to improve brain-body communication and overall health. I have read and agree to Patient Rights and Responsibilities policies of Throm Health and Wellness.

_____
Initials

Signature: (By signing below I agree to the above initialed statements)

_____ Date

_____ Printed Name

_____ Signature

Authorization for Care of a Minor:

I, _____ [Parent/Guardian] permit _____ [Patient] to receive care at Throm Health and Wellness in my absence. (This allows other family members to bring your young child in for care or to have an older child come for his/her appointments on their own)

Signature: _____ Relationship to Patient:_____

Doctor Signature_____