**Patient Admittance Form**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial\_\_\_\_\_\_

Address City State Zip code\_\_\_\_\_\_

Home Phone ( ) Cell Phone ( ) Work Phone ( )\_\_\_\_\_\_\_\_\_\_

Date of Birth Marital Status How did you hear of us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\* Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements & promotions**

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Emergency Contact's Phone ( )\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION TO TREAT A MINOR (PARENT OR GUARDIAN)**

I give Zeiszler Chiropractic Clinic permission to examine, X-Ray, and treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT FINANCIAL INFORMATION**

Circle One: General Insurance Cash Payments Personal Injury

Workman's Compensation Other

Insurance Company Name Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury/Occurrence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.**

Patient Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zeiszler Chiropractic Clinic

14635 Pennock Avenue, Suite #200

Apple Valley, MN 55124

(952) 432-0700

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**Patient Health Questionnaire—Page 2**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of regular exercise do you perform?** None Light Moderate Strenuous

**What is your height and weight?** **Height:**\_\_\_\_\_\_\_ **Weight:**\_\_\_\_\_\_\_ lbs

**For each of the conditions listed below, place a check in the *Past* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *Present* column.**

**Past Present Past Present Past Present (Females Only)**

\_\_\_ \_\_\_ Headaches \_\_\_ \_\_\_ Kidney Stones \_\_\_ \_\_\_ Birth Control Pills

\_\_\_ \_\_\_ Neck Pain \_\_\_ \_\_\_ Kidney Disorders \_\_\_ \_\_\_ Hormonal Replacement

\_\_\_ \_\_\_ Upper Back Pain \_\_\_ \_\_\_ Bladder Infection \_\_\_ \_\_\_ Pregnancy

\_\_\_ \_\_\_ Mid Back Pain \_\_\_ \_\_\_ Painful Urination

\_\_\_ \_\_\_ Low Back Pain \_\_\_ \_\_\_ Loss of Bladder Control

\_\_\_ \_\_\_ Shoulder Pain \_\_\_ \_\_\_ Prostate Problems

\_\_\_ \_\_\_ Elbow/Upper Arm Pain \_\_\_ \_\_\_ Abnormal Weight Gain/Loss

\_\_\_ \_\_\_ Wrist Pain \_\_\_ \_\_\_ Loss of Appetite

\_\_\_ \_\_\_ Hand Pain \_\_\_ \_\_\_ Abdominal Pain

\_\_\_ \_\_\_ Hip/Upper Leg Pain \_\_\_ \_\_\_ Ulcer

\_\_\_ \_\_\_ Knee/Lower Leg Pain \_\_\_ \_\_\_ Hepatitis

\_\_\_ \_\_\_ Ankle/Foot Pain \_\_\_ \_\_\_ Liver/Gall Bladder Disorder

\_\_\_ \_\_\_ Jaw Pain \_\_\_ \_\_\_ Cancer

\_\_\_ \_\_\_ Joint Swelling/Stiffness \_\_\_ \_\_\_ Tumor

\_\_\_ \_\_\_ Arthritis \_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ Rheumatoid Arthritis \_\_\_ \_\_\_ Chronic Sinusitis

\_\_\_ \_\_\_ General Fatigue \_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ Muscular Incoordination \_\_\_ \_\_\_ Excessive Thirst

\_\_\_ \_\_\_ Visual Disturbances \_\_\_ \_\_\_ Frequent Urination

\_\_\_ \_\_\_ Dizziness \_\_\_ \_\_\_ Smoking/Tobacco Use

\_\_\_ \_\_\_ High Blood Pressure \_\_\_ \_\_\_ Drug/Alcohol Dependence

\_\_\_ \_\_\_ Heart Attack \_\_\_ \_\_\_ Allergies

\_\_\_ \_\_\_ Chest Pains \_\_\_ \_\_\_ Depression

\_\_\_ \_\_\_ Stroke \_\_\_ \_\_\_ Systemic Lupus

\_\_\_ \_\_\_ Angina \_\_\_ \_\_\_ Epilepsy

\_\_\_ \_\_\_ Chronic Sinusitis \_\_\_ \_\_\_ Dermatitis/Eczema/Rash

**Indicate if any family member has had any of the following:**

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus

**List all prescription and over-the-counter medications and nutritional/herbal supplements you are taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all of the surgical procedures you have had and times you have been hospitalized:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health Information Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office as well as your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form, stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the Insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient’s written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during the care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_