Hapeman Rodriguez Chiropractic

"Adjusting You to a Better Quality of Life"

Welcome and thank you for choosing our practice for your chiropractic and healthcare needs. Please complete this form the best you can. If you have any questions, please ask.

Name____ **Birthday**____/____/____ **Social Security #**____/____/____

Address____ **City**________________ **State**_________ **ZIP**___________

Phone ___________________________ **Home/Cell/Work** **2nd #**______________________________ **Home/Cell/Work**

Gender: M / F **Are you (circle one): Married Widowed Single Minor Separated Divorced Partnered**

Preferred Language:______________________ **Race:**______________________ **Ethnicity:**_________________________

Are you (circle one): Student Employed Unemployed At Home Parent Retired Other

Spouse / Parent_______________________________________ **Referred by:**_____________________________________

Emergency Contact____ **Phone**_____________________

SYMPTOMS

Reason For Visit____ **First Noticed?**____________________________

Is This Condition Getting Progressively Worse?____

Where Specifically Is The Problem Located?____

Which Activities Are Difficult? (Circle all that apply)

Sitting Standing Walking Bending Lying Down

TYPE OF PAIN (CIRCLE ALL THAT APPLY)

Sharp Dull Aching Throbbing Numbness Burning Shooting Tingling
Tightness Stiffness Diffuse Other: ____

RATE THE SEVERITY OF YOU PAIN (1=MILD DISCOMFORT TO 10 SEVERE PAIN) 1 2 3 4 5 6 7 8 9 10

Is the pain : Constant Frequent Intermitted Occasional

What treatment have you received/done for this condition?____

Have you had any X-rays / CT / MRI? Y or N WHEN?____________________________________ **Arnot / Guthrie / Other**

Primary Care Physician____ **Circle one: Arnot / Guthrie / Private**

Height_____________________ **Weight**______________ **Blood Pressure**__________/__________ **Heart Rate** __________

Date of last physical exam_______________________________________ **Women Only: Pregnant / Nursing / Birth Control**

Hapeman Rodriguez Chiropractic

"Adjusting You to a Better Quality of Life"

HEALTH HISTORY – check only those conditions that apply to you

- ☐ **AIDS/HIV**
- ☐ **Alcoholism**
- ☐ **Allergy Shots**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Cancer**
- ☐ **Cataracts**
- ☐ **Chemical Dependency**
- ☐ **Chicken Pox**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Fractures**
- ☐ **Gout**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **Hernia**
- ☐ **Herniated Disc**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Lyme Disease**
- ☐ **Migraines**
- ☐ **Miscarriages**
- ☐ **Mononucleosis**
- ☐ **Motor Vehicle Accident**
- ☐ **Multiple Sclerosis**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Parkinson's Disease**
- ☐ **Prostate Problems**
- ☐ **Prosthesis**
- ☐ **Psychiatric Care**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Stroke**
- ☐ **Thyroid Problems**
- ☐ **Tuberculosis**
- ☐ **Tumors, Growths**
- ☐ **Other**

List any type of surgeries which you have had and dates when they occurred:____________________________________

____

For your convenience, we can make a copy of your medication list.

Medication / OTC / Vitamins / Supplements	Dosage and Frequency

Drug Allergies:____

DAILY HABITS

What types of exercise do you perform on a daily basis? **None / Moderate / Heavy / Housework**

Smoking Status (circle one): Everyday / Occasional / Former / Never

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health status.

PRINT NAME____ **DATE** ______________________

Signature:____ **Relationship:**______________________

Hapeman Rodriguez Chiropractic

"Adjusting You to a Better Quality of Life"

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

To Whom It May Concern: Date _____/____/_____

I, ________________________ hereby authorize the release of the following medical records to:

- ☐ X-ray Reports
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Emergency Dept.
- ☐ Other - _______________

Dr. Donna H Rodriguez, DC
Hapeman Rodriguez Chiropractic
460 E. Church Street
Elmira, NY 14901-2832
P – 607-733-3235 F – 607-733-4036

Signature____ Birthdate _____/____/_____

Dr. Donna H Rodriguez – Hapeman Rodriguez Chiropractic

460 E. Church Street, Elmira, NY 14901-2832 (607)733-3235 Fax (607)733-4036

I certify that I, and/or my dependent(s), have insurance with _____________________________ and assign directly to Dr. Donna H Rodriguez all insurance benefits, if any, otherwise payable to be for services rendered. I understand that I am financially responsible for all charges incurred at this office including co-payments, deductibles, and charges denied or not covered by my insurance company. I authorize the use of my signature on all insurance submissions.
I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary. I understand that my coverage does not cover routine maintenance, preventative or wellness visits.
The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is complete or one year from the date signed below.

Cardholder's Name Relationship to Insured **Cardholder's Date of Birth**

Signature of Patient, Insured, or Parent / Guardian Today's Date

Hapeman Rodriguez Chiropractic

"Adjusting You to a Better Quality of Life"

HIPPA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 & 164)

I hereby understand that as part of my healthcare, this practice originated and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information to applying my diagnosis and surgical information (if necessary) to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to object to the use of my health information for directory purposes. I also have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

- ☑ Mental Health Records
- ☑ Communicable Diseases (including HIV or AIDS)
- ☑ Alcohol / Drug Abuse Treatment
- ☑ Other (please specify):____

I fully understand and ✔ accept or ✔ decline the terms of this contract.

Print Name________________________________ Today's Date ______________

Signature ________________________________

Submit