Patient Case History & Information

Date: _____ Patient #_____ **Doctor:** _____

Name: _____ Social Security #_____Home Phone: _____

Address: _____City, State, Zip: _____

E-mail address: _____ Cell Phone: _____ Best Way to Reach You? _____

Age: _____ Birth Date: _____ Sex: M F Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

Who is responsible for the account (minors only): _____

Address for the Acct. Responsible (minors only): _____

In Case of Emergency: _____ Address: _____Phone: _____

Family Medical Doctor: _____ Phone #: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ Date of last physical examination: _____

HISTORY OF PRESENT CONDITION:

Chief Complaint- Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other_____ Days lost from work: _____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe: _____

_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from?
(Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Questions/Concerns you may have about your care:

Rank from Greatest (4) to Least (1)

____ Time constraint/My Busy Schedule
____ The Chiropractic Adjustment
____ Financial Concerns
____ How Long My Care Will Take
____ I have no Questions/Concerns

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Has a physician treated you for any health condition in the last year? π Yes π No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe: _____

Do you have any allergies of any kind? π Yes π No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be:
_____
_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? _____Do you smoke? ____ If so, packs per day: _____
Do you take vitamin supplements? _____ If so, please list: _____
Do you consume caffeine? ____ If so, how much per day: _____
Do you exercise? _____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
Father: living___ deceased____ Current age if still living: _____ Cause of death and age at death if deceased:

Mother: living___ deceased____ Current age if still living: _____ Cause of death and age at death if deceased:

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:
_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

Please check any and all insurance coverage that may be applicable in this case:
π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company: _____
Subscriber Name: _____ Relation to Patient: _____
Name of Secondary Insurance Company (if any): _____
Subscriber Name: _____ Relation to Patient: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless 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.

The patient understands and agrees to allow this chiropractic office 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.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Moon Chiropractic** to disclose certain protected health information (PHI) about me for the following purposes only (please read and check boxes):

□ Confirmation calls for appointments

□ Email reminders for upcoming events

□ Newsletter via email

□ Other _____

Signature: _____

My signature below acknowledges that I have been offered to receive a copy of the Practice's Privacy Notice that has an effective date of April 3, 2003.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Moon Chiropractic, 410 Rouser Road, Moon Township, PA 15108

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian if applicable

Moon Chiropractic Patient Policies

1. **Your Treatment**- Please follow the treatment plan prescribed to you by Dr. Spiropoulos. Your plan is basked on your condition and our ability to treat that condition. If you wish to achieve optimal results, you will need to come to your visits, perform your exercises and do your home care. We will give you 110%. We expect the same effort from our patients. **If your condition would change, please alert the front desk staff so that Dr. Spiropoulos can properly examine your condition.**

2. **Appointments**- We respect the busy lives of our patients and we give our best to honor their appointments with punctuality. We ask that our patients have that same respect for our schedule. We respectfully ask that you come to your appointments on time and that if you need to cancel your appointment, please do so 24 hours prior to that appointment time. We do understand that things come up from time to time with family and work.
We understand that short notice cancellations will occur. We simply ask that they do not become habitual.

3. **Cell Phone Usage**- We ask that you refrain from cell phone use after leaving the front reception area. Cell phone use can have a negative effect on our therapy machines and they disturb the relaxed atmosphere of our facility. Please turn your phone off. Thank you.

4. **Financial Services**- If you have any changes to your insurance during your treatment, it is imperative that you alert the front staff. We always want to know what is covered under your plan as it helps to eliminate billing mishaps. We ask that each patient make payment upon receiving services. Financial arrangements may also be made with our Billing Department.

Thank you for choosing Moon Chiropractic for your healthcare needs. Our goal is to exceed all of your expectations, both on a healthcare and customer service basis. In order to do this, we ask you to please be compliant with the above policies.

It is our primary goal to make sure that you have an extraordinary experience at our facility. We feel very passionate about the positive impact that chiropractic care will have on your life. We depend on our patients to spread the word about our commitment to their care. Please, tell your family and friends about your experience and encourage them to use our facility when they need us. We truly appreciate your referrals!

_____ _____

Patient Signature Date

How did you hear about us?

Please circle one and provide additional information as requested. Thank you.

1. Family/Friend/Co-worker

Name: _____

2. Advertisement

Publication: _____

3. Building Sign

4. Insurance Plan

a. Book

b. Online

5. Physician Referral

Dr's Name: _____

6. Internet Search

7. Contacted by one of our Marketing Agents

8. Speaking Engagement/ Outreach Even

Name of Event: _____

9. Health Screening

Location:_____