



# New Patient Information

For office use only
Patient #: _____
Doctor: _____
Date: _____

### ABOUT YOU:

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: S  M  D  W

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Preferred: H  W  C

Employer Name: \_\_\_\_\_ Employer Ph: \_\_\_\_\_ Occupation: \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Have you ever seen a Chiropractor? Yes  No  If yes, when? \_\_\_\_\_

Do you smoke? Yes  No  How many packs/day? \_\_\_\_\_ Do you have a pacemaker? Yes  No

Have you been treated for any health conditions by a physician in the last year: Yes  No

If Yes, then describe: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ List surgeries: \_\_\_\_\_

Serious illnesses: \_\_\_\_\_

What vitamins/medications are you taking? \_\_\_\_\_

If female, are you pregnant? Yes  No  Are you taking birth control? Yes  No

### ABOUT YOUR FAMILY:

Name of Spouse (or parent if minor): \_\_\_\_\_

Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_

Address: \_\_\_\_\_ Home Ph: \_\_\_\_\_

### ABOUT YOUR CONDITION:

1) Do you suffer from (check all that apply):

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Hip/Leg Pain	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Sinus Disorder	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Restless Leg	<input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> Male/Female Issues
<input type="checkbox"/> Headaches	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Urinary Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Numbness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Other: _____

2) Purpose of this appointment/current problem(s): \_\_\_\_\_

3) Other doctors seen for this condition: \_\_\_\_\_

4) Date symptoms appeared or accident happened: \_\_\_\_\_ Days lost from work:  Yes  No How many? \_\_\_\_\_

5) Is the condition due to:  Work  Auto  Other: \_\_\_\_\_

6) Is the condition:  Constant  Intermittent Over time the condition has:  Increased  Decreased  No change

7) Have you ever had the same or similar condition?  Yes  No If yes, When? \_\_\_\_\_

8) Is there anything you can do which provides relief (check all that apply):

Ice  Heat  Medication  Stretching  Sitting  Lying  Exercise  Other: \_\_\_\_\_

9) What makes the condition worse (check all that apply):

Lifting  Bending  Turning  Lying  Sitting  Standing  Walking  Other: \_\_\_\_\_

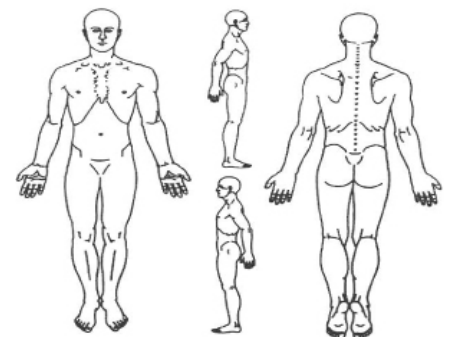
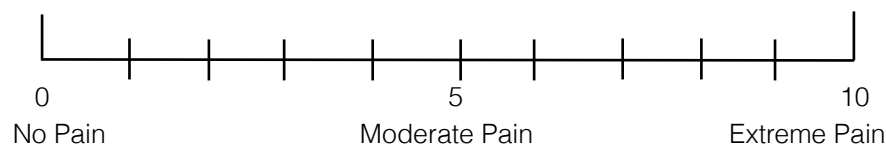
10) Describe your condition.

Sharp  Aching  Dull ache  Burning  Throbbing  Tingling

Stabbing  Shooting  Numbness  Other: \_\_\_\_\_

11) Please circle your symptom areas:

12) Rate the severity of your condition. You may also indicate areas and their associated pain level.



**CONSENT FOR TREATMENT:** I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). 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 doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual percentage rate of 16%.

**RELEASE OF INFORMATION:** By signing this form, you are granting consent to Reese Chiropractic & Wellness P.C. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient or Guardian Signature Authorizing Care (Sign on the line above.)

Date

**MEDICAL RELEASE OF INFORMATION:** When it comes to your health, we believe medical doctors and chiropractors should work together for Your benefit.

Reese Chiropractic agrees! I give you permission to inform my personal medical doctor of my condition, treatment, and expected actual response to care at this office.

Your Medical Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Signature of Patient or Guardian (Sign on the line above.)

Date

**ASSIGNMENT OF BENEFITS:**

Insured's Name: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Claim# (if applicable): \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check, made out to and mailed directly to:

J Weston Heath Reese, D.C.  
dba Reese Chiropractic & Wellness P.C.  
1505 S Sangre Rd  
Stillwater, OK 74074

If my current policy prohibits direct payment to my doctor, then I hereby instruct and direct you to make the check payable to me and mail it to:

J Weston Heath Reese, D.C.  
dba Reese Chiropractic & Wellness P.C.  
1505 S Sangre Rd  
Stillwater, OK 74074

for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS, TITLES INTERESTS, AND BENEFITS TO THIS OFFICE UNDER THE POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, and balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Dated in Payne County, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Signature of Insured and/or Claimant \_\_\_\_\_

Signature of Witness \_\_\_\_\_