NEW PATIENT HEALTH HISTORY FORM

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ EMAIL* _____

*Your email will NOT be shared with any 3d parties, and is used for occasional office announcements or promotions.

Mailing Address

Address _____ City _____ State _____ Zip _____
Telephone (home) _____ (cell) _____ (work) _____ Referred By _____
Age _____ Birth Date _____ Social Security # _____ Number of children _____
Occupation _____ Employer _____
Marital Status _____ Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Health Status _____
Emergency Contact _____ Phone _____

Current Complaints

Nature of injury: ☐ Automobile* ☐ Work ☐ Other
Please describe: _____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? ☐ No ☐Yes If yes, When? _____
List of other practitioners seen for this injury/condition _____
Have you ever been under chiropractic care? ☐ No ☐ Yes
If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____
Do you have health Insurance? ☐ No ☐ Yes Name of company _____
***If an auto accident, please provide:**
Insurance Company Name _____ Contact Person _____
Phone _____ Claim # _____

Signatures

Name of the insured _____

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's Signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ☐ NO ☐ Yes
If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ NO ☐ Yes

Have you had X-rays taken? ☐ NO ☐ Yes If Yes, where? _____
What medications are you taking and for what conditions (Please list dosage and amounts, etc)_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency). _____

_____

Have you ever:	No	Yes	Briefly Explain
Broken Bone?	☐	☐	_____
Been Hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious	☐	☐	_____
Had Surgery?	☐	☐	_____

Family History

Family Members- Present and past health condition (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	☐No	☐Yes
Do your symptoms interfere with daily life?	☐No	☐Yes
Does pain wake you up at night?	☐No	☐Yes
Are your symptoms worse during certain times of the day?	☐No	☐Yes
Do changes in weather affect your symptoms?	☐No	☐Yes
Do you wear orthotics?	☐No	☐Yes
Do you take vitamin supplements	☐No	☐Yes

What activities aggravate your symptoms? _____

_____

_____

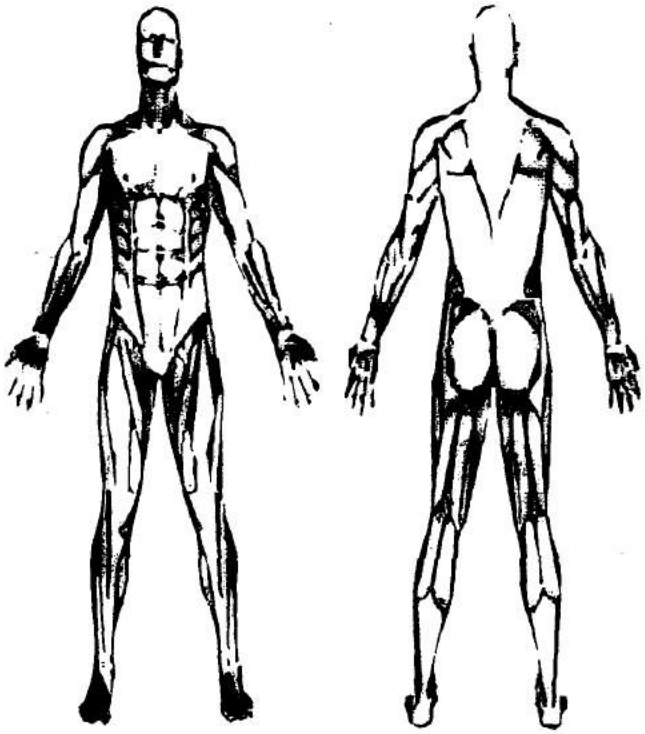
Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

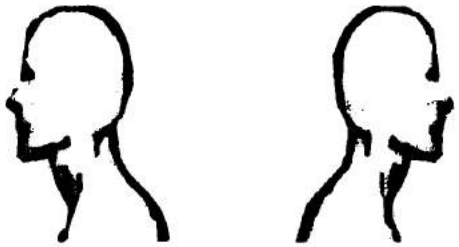
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing





Riverview Chiropractic
Consent to Care

A patient coming to the doctor gives him permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient Signature **Date**

Riverview Chiropractic
Robert W. Haug, D.C.

1466 Riverside Drive, Suite C
Chattanooga, TN 37406
Phone: (423) 643-2211
Fax: (423) 643-2210

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received or reviewed the privacy practice notice (4 pages) for Riverview Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. _____ (initial)

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement. _____ (initial)

1. Do we have your permission to confirm appointments at your home? ____ Yes ____ No

2. Do we have your permission to leave the following information on your voicemail?
   - Appointment information _____ Yes _____ No
   - Billing information _____ Yes _____ No
   - Medical information _____ Yes _____ No

   Do you prefer this information be left on your home, work, or cell voicemail? _____

3. I give permission to share appointment, medical, and/or billing information with the person(s) named below:
   _____
   _____

_____ _____
Patient Signature Date

_____
Print the Patient Name

Riverview Chiropractic

Dr. Robert Haug, D.C.
1466 Riverside Drive, Suite C
Chattanooga, TN 37406

FINANCIAL POLICY

- Payment is due at the time services are provided.
  - We accept cash, checks, Visa, and MasterCard.
  - We reserve the right to delay the scheduling of future appointments until the account is in good standing.

- As a courtesy, Riverview Chiropractic will file your insurance claims.
  - We also try to verify your coverage before your visit. The benefit information given to us is only an abbreviated list and does not guarantee payment.
  - If you need specifics regarding your policy's benefits, exclusions, riders, pre-existing condition clauses, or other information you will need to contact them directly by calling the number listed on the back of your identification card.

- All incurred charges are ultimately the responsibility of the patient, regardless of insurance coverage.
  - We must emphasize that as your health care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company. Our office is not a party to that contract and any possible restrictions.

- Returned checks will include a $25.00 service fee.

- If your account is turned over for collection, you are responsible for, in addition to your principle balance, reasonable attorney's fees, interest at the yearly rate of 18% and all costs of collection, including court costs. You further agree that the proper jurisdiction and venue for such collection is the General Sessions or Chancery Courts of Hamilton County, Tennessee.

- We charge a $35.00 fee for missed appointments when not cancelled or rescheduled with a two hour notice or more. As a courtesy to patients who may be on a waiting list, please try to provide a twenty-four hour notice if you need to reschedule an appointment.

I have had the opportunity to review the above financial policy and understand it and freely and voluntarily agree to abide by such. If the patient is under the age of 18, a legal guardian's signature is required as a guarantee.

Patient's or guardian's signature: _____ Date: _____

Guarantor's signature: _____ Date: _____