WELCOME TO
SEABROOK CHIROPRACTIC & WELLNESS CENTER
SPINAL CORRECTIVE CARE FOR THE ENTIRE FAMILY

ADULT

Today's Date: ____/____/_____

Full Name: _____ What would you prefer to be called? _____

Street Address (If P. O. Box, provide street address also.):

_____

City: _____ State: _____ Zip Code: _____

Home #: (___) _____ Work #: (___) _____ Cell #: (___) _____

Email address: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: Please circle- Single / Married / Divorced / Separated / Widowed

Spouse's Name: _____ Name of Children: _____

Hobbies: _____

Patient's Employer/Business: _____

Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Have you had a work related injury? Yes No Auto Accident? Yes No

How did you learn about our office? _____

Any previous Chiropractic Care? Yes* No *Approximate last time seen: _____

Do you take any vitamin supplements? Yes* No

*If Yes, what_____

Do you have health insurance? Yes* No
*If Yes, please complete the back of this page and provide a copy of the insurance card.

Are you a student? Yes* No *Approximate years remaining: _____

REQUIRED INFORMATION SIGNATURE FOR THIRD-PARTY (i.e. INSURANCE) BILLING

Policy Holder/Employee Subscriber: Please circle - Self / Spouse / Parent / Other

Policy Holder Information:

Full Name: First: _____ Middle: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: (___) _____ Work Number: (___) _____

Work Name: _____

Work Address: _____ City: _____ State: _____

Date of Birth of Subscriber: _____ Social Security Number: _____

Patient's or Authorized Person's Signature:
I authorize the release of any medical or other information necessary to process my claim. I understand that some information may go electronically or by fax. I also request payment of government benefits or insurance benefits either to myself or to Seabrook Chiropractic & Wellness Center, LLC that accepts assignment on an individual basis.

Insured's or Authorized Person's Signature:
I authorize payment of medical benefits to Seabrook Chiropractic & Wellness Center, LLC. for services rendered.

Disclosure of Insurance benefits:
I agree to present all my eligible insurance or Medicare beneficiary cards to Seabrook Chiropractic & Wellness Center, LLC. (Mark Lique, D.C.) upon request, to verify coverage and benefits. In the event of personal injury cases or Worker's Compensation, I will supply all information at the time of visit for prompt benefit payment.

Denial of Insurance payments:
If payment is denied by my approved payment source, I agree to pay for services in full within 30 days.

Sign: _____ Date: _____

Print name of patient: _____

SEABROOK CHIROPRACTIC & WELLNESS CENTER
SPINAL CORRECTIVE CARE FOR THE ENTIRE FAMILY

CONFIDENTIAL HEALTH ENTRANCE FORM

Full Name: _____ **Date:** _____

PLEASE LIST REASON(S) BELOW FOR PURSUING CHIROPRACTIC CARE TODAY:

Primary Reason:

Secondary Reason:

Other:

IN ORDER FOR US TO BETTER UNDERSTAND YOUR CURRENT LEVEL OF HEALTH, PLEASE **CHECK** ANY OF THE BODY SIGNALS WHICH **YOU** HAVE OR HAVE HAD PREVIOUSLY:

____ Allergies
____ Arthritis
____ Asthma
____ Bladder Problems
____ Dizziness or fainting
____ Ear Infection
____ Frequent Cold/Flu
____ Kidney Problems
____ Headaches
____ High Blood Pressure
____ Intestinal Problems
____ Menopausal Symptoms
____ PMS
____ Prostate Trouble
____ Postural Imbalance
____ Short Leg/Orthotics
____ Sinus Problems

CHECK THE FOLLOWING CONDITIONS THAT **YOU** HAVE OR HAVE HAD:

___ Alcoholism
___ Cancer
___ Diabetes
___ Epilepsy
___ Hyper/Hypothyroidism
___ HIV
___ Heart Disease
___ Lung Disease
___ Multiple Sclerosis
___ Scoliosis
___ Stroke
___ Ulcers

CHECK THE CONDITIONS THAT ARE COMMON TO **FAMILY MEMBERS**:

___ Alcoholism
___Hyper/Hypothyroidism
___ Multiple Sclerosis
___ Cancer
___ HIV
___ Scoliosis
___ Diabetes
___ Heart Disease
___ Stroke
___ Epilepsy
___ Lung Disease
___ Ulcers

List the prescription **or** over-the-counter medications you are currently taking:

_____

_____

Known Allergies:

_____

_____

CONFIDENTIAL HEALTH FORM AND STRESS TEST

The following areas of stress can cause mis-aligned vertebra (Subluxation).
Which of these stresses do you recognize?
Please circle when you experienced these stresses.
C (Child), T (Teenager), A (Adult)

Physical/Emotional/Chemical Stresses:				**Comments**
Birth Trauma	C	-	-	
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injury	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	-	T	A	
Work Injuries	-	T	A	
Sitting on a Wallet	-	T	A	
Sleeping on Stomach	-	T	A	
Extensive Computer Work	-	T	A	
Carrying Heavy Purse/Book bag/Child	-	T	A	
Repetitive Lifting/Bending	-	T	A	
Driving for Many Hours	-	T	A	
Continuous Hours Sitting/Standing	-	T	A	
Children Stress	-	-	A	
Career Stress	-	-	A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount: _____
Poor Diet/Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over-The-Counter Drugs (ex. Tylenol, Motrin)	C	T	A	

Which do you feel are your primary stresses?

_____

It is important that we and our patients have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given on this form is complete and accurate and that you accept, if eligible, chiropractic care on this basis.

Sign Your Name: _____ Date: _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at **Seabrook Chiropractic & Wellness Center, LLC,** we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, inform you of health related meetings, workshops or products or and other information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further**,** you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

If you would like further information about our privacy policies and practices please contact: Mark Lique, DC or Edward J. Rusher, DC

This office utilizes an **"open-adjusting"** environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

It is our desire for our staff to use your name, signature, photograph and/or radiograph on our Patient of the Week and Month, Referral Boards, S-Ray view boxes, family picture wall, Newsletter and In-Office promotions.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office or workshop visit.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality Chiropractic care.

This notice is effective as of April 1, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Please Print) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative (Print) Personal Representative Signature Date