



CROSBY CHIROPRACTIC CENTER, P.C.

CONFIDENTIAL PATIENT HEALTH INFORMATION

Personal Demographics

Name _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Birthdate: _____ Age: _____
Cell Phone: _____ Social Security #: _____
E-mail: _____
Business Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____
Number of Children: _____ Referred to this office by: _____

Current Health Condition

Chief Complaint: _____
Secondary Complaint: _____
Other doctors seen for this condition? Yes No
Who? _____ Results: _____
Type of Treatment: _____ Has this condition occurred before? Yes No
When did this condition begin? _____
Is condition: Job related Auto Fall Home Injury Other: _____
Date of Accident: _____ Time of Accident: _____
Drugs you now take: _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Past Health Condition

Previous Surgery/Operation: _____
Major Accidents or Falls: _____
Hospitalization (other than above): _____
Previous Chiropractic Care: Yes No
Dr.'s Name and approximate date of last visit: _____

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

- | | | | | |
|------------------------------------------|----------------------------------------|----------------------------------------------|----------------------------------------|-------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | Intake | Amount/Day |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coffee/Tea | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Cigarettes | _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Soft Drinks | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Eczema | <input type="checkbox"/> Energy Drinks | _____ |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST

Musculo-Skeletal

- Low Back Pain
- Pain between shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Gastrointestinal

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems

- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody stool
- Colitis

Genito-Urinary

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose
- Sinus Problems

Females Only:

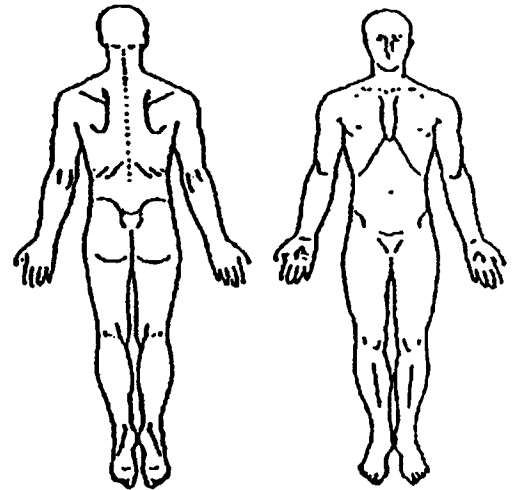
When was your last period?

Are you pregnant?
 Yes No

Male/Female

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Dysfunction
- Other Problems

Please outline on the diagram the area of your discomfort

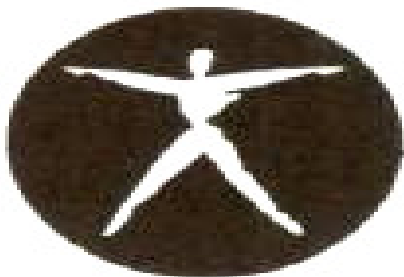


Family History of Spinal Problems

- Mother _____
- Father _____
- Brother _____
- Sister _____
- Spouse _____
- Child _____

Thank you for choosing our office. Since 1982 we have helped thousands find better health and enjoy a more active and full life. We look forward to helping you. Dr. Rob Rosenbaum, D.C.

Patient Signature _____ Date _____



Crosby Chiropractic and Wellness Center

This office is pleased to accept your case on assignment as soon as we verify your coverage with your insurance company or responsible party. We will file your claim forms to assist you in every way we can for reimbursement. However it must be understood that insurance contracts are between you and your insurance company.

I certify that I, and/or my dependant(s) have insurance with _____ and assign directly to Dr. Rob Rosenbaum all insurance benefit, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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 payment for services and determining insurance benefits or the benefits payable for related services.

You are responsible for any amount not paid by your insurance company. Your insurance company should pay within 30 days. If your insurance company has not paid within 60 days then you are required to pay the balance due. You will be reimbursed by your insurance company if and when it pays.

We will do all we can to help you obtain your insurance benefits but we will not enter into a dispute with your insurance company. This is your responsibility and obligation since the contract is between you and your insurance company.

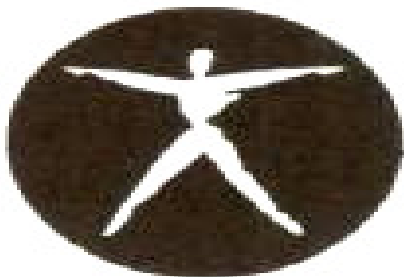
If you understand and agree with all the above policies, sign your name below and we will accept your insurance.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent Guardian or Personal Representative

Date

Relationship to Patient



Crosby Chiropractic and Wellness Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Crosby Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Date

Signature

Print Name

FOR USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good faith effort to obtain an acknowledgment of _____ (patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patient acknowledgment, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- Personally
- Mail
- Other: _____

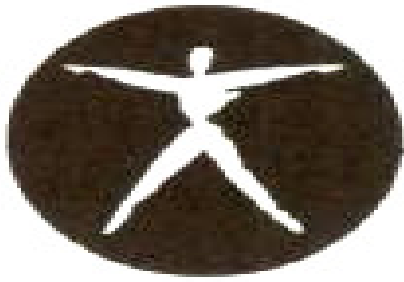
Date

Signature

Print Name of Physician

Crosby Chiropractic

Name of Practice



Crosby Chiropractic and Wellness Center

Consent for Purposes of treatment, Payment and Healthcare Operations

I, _____, consent to Crosby Chiropractic's use of disclosure of my Protected Health Information for the purpose of providing treatment to me, for purpose relating to the payment of services rendered to me, and for the Practice's general healthcare operation purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" mean any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; of the past, present or future payment for the provision of health care service to me and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority