Earnst
CHIROPRACTIC CLINIC

231 Baker Road, High Point, NC 27263
336-434-4600

PATIENT INTRODUCTION FORM

No. _____ Date _____

Name (Mr., Mrs., Miss, Ms.) _____

Phone _____ Email _____

Home Address,_____ City, State, Zip _____

Social Security No. _____ Cell phone _____ Office Phone _____

Age _____ Date of Birth _____/_____/_____ □ Married □Single □Widowed □ Sep/Div.

Occupation_____ Employer & Address_____

Previous Chiropractic Care □ Yes □ No Doctor's Name _____

Major Complaint _____

Nearest relative or friend who may be contacted in case of emergency _____

Relationship _____ Phone _____

Who (or what source) referred you? _____

Name of Health Insurance Company _____

Is insurance under your name? □Yes □No If NO, please fill out the following:

1st Insured's Relationship to You: □Spouse □Parent □Other

1st Insured's Name _____ 1st Insured's Social Security No. _____

1st Insured's Employer _____ 1st Insured's Date of Birth _____/_____/_____

1st Insured's policy no. _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Earnst Chiropractic, (Dr. W. Tyler Earnst D.C.) to furnish my Insurance Co. with a full report of physical examination, diagnosis, prognosis, etc. if myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owning him for chiropractic service rendered to me. I understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature _____ Date _____

EARNST PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ **Date** _____

1) Reason for today's visit: □ **emergency** □ **new injury** □ **old injury** □ **chronic pain** □ **wellness visit**

2) When did your symptoms start? (DATE) _____

3) Did symptoms occur during: □ **work** □ **sports/play** □ **auto accident** □ **routine/household activity**

4) Describe your symptoms & how they began: _____

_____

USING THE ADJACENT BODY CHARTS, PLEASE MARK ALL AFFECTED AREAS.

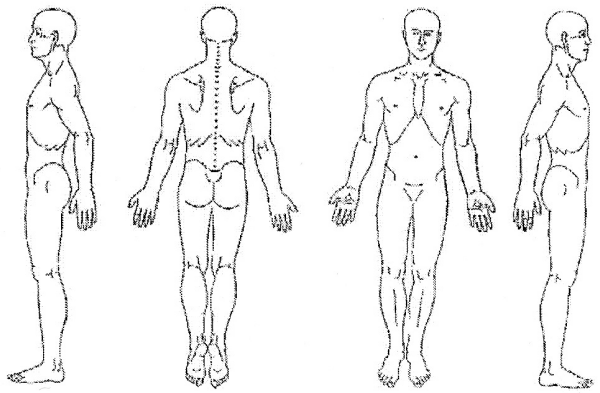
5) How often do you experience your symptoms?

□ **constantly (100% of the day)**

□ **frequently (75% of the day)**

□ **occasionally (50% 0f the day)**

□ **intermittently (25% of the day)**



6) What describes the nature of your symptoms?

□ **sharp** □ **shooting**

□ **dull ache** □ **burning**

□ **numbness** □ **tingling**

7) How bad are your symptoms at their: Worst: **discomfort 1 2 3 4 5 6 7 8 9 10 intense**

(Rate pain with the following scales) Best: **discomfort 1 2 3 4 5 6 7 8 9 10 intense**

8) What activities make your symptoms worse? _____

9) What activities make your symptoms better? _____

10) Have you ever been treated by anyone for your symptoms? □ **yes** □ **no If so, where?** _____

11) What tests have you had for your symptoms? (e.g., x-rays, MRI, CT scan). List test and date:

_____

12) Have you ever been treated by a chiropractor? □ **yes** □ **no** **Clinic or Dr's name:** _____

13) Has this or something similar happened in the past? □ **yes** □ **no** **Explain:** _____

If any of the following are relevant to your medical history, please circle:

headaches	shoulder pain	digestive disorders	cancer	epilepsy
neck pain	elbow/upper arm pain	kidney trouble	asthma	HIV/AIDS
mid back pain	wrist/hand pain	bladder trouble	sinus trouble	hormonal replacement
low back pain	visual disturbance	prostate problems	diabetes	pregnancy
jaw pain	dizziness	abdominal pain	smoking/use tobacco	multiple sclerosis
hip/upper leg pain	high/low blood pressure	ulcer	allergies	muscular dystrophy
knee/lower leg pain	heart trouble	hepatitis	depression	arthritis
ankle/foot pain	stroke	liver/gall bladder trouble	dermatitis/eczema/rash	general fatigue

14) Indicate if an immediate family member has had any of the following:

□ **rheumatoid arthritis** □ **heart problems** □ **diabetes** □ **cancer** □ **lupus** □ **other:** _____

15) Are you currently taking any medications? Please List: _____

_____

16) Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

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NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Earnst Clinic, 231 Baker Road, High Point, NC 27263 (336) 434-4600

WRITTEN ACKNOWLEDGEMENT
I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I resquest.

_____ _____

Signature of Patient or Legal Representative Date