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.

First Name	Last Name	Date	Emgil*	
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* YOUr	email will NOT be shared with any	3d parties, and is used for	r occasional office announc	ements and promotion
Mailing addres	S			
Address		City	State	Zip
felephone (Work)	(hor	ne)	Referred By	
Age Birth	Date Social	al Security #	Number of Children	
Occupation		Employer		
Marital Status	Spouse's Name		Spouse's Occupation	
Spouse's Employer		Spouse's Health Stat	us	
Emergency Contact		Phone		
	L			
Current Compl	aints	4500 P. J. Her.	AUSTIN SCHOOL	W455 4
Nature of Injury:	The second secon	Tau		
Talois of Injuly.	Automobile* Work	Other		
Please describe:				
Dada at labar	Data sumatan	s are all		
Date of Injury	Date symptoms app	L		
	same condition? O No O Yes	If yes, when?		
	ners seen for this injury/condition	The Tribut Systems of the Control of		
	under chiropractic care? O No	O Yes		
If yes, please describ	99			
Insurance Info	mation			Photograph 4
	onsible for payment		Phone	
		ne of company		
* If an auto accident Insurance Company		Contact Person		
Phone:	Claim #	Confact Person		
rnone.	Claim #			
		Barra and American		
Signatures				48 Sept 26 18 1
Name of the ins	urad			*
Number of the Inst	I understand and agree that	health/accident Insurance po	olicies are an arrangement betw	veen an insurance carrie
	and myself. I understand an	d agree that all services rend	lered to me and charged are m	v personal
	professional services render	ment. I understand that if I sed to me will be immediately	uspend or terminate my care/ti due and payable.	reatment, any fees for
Patient's signatu	rerdian's signature		B 가는 사용 (2) (2) (2) (2) (2) (2) (3) (3) (3) (4) (3) (3) (4)	
			Date	

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Ulcers		
Varicose Veins	Ulcers	412
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Venereal Disease	Other:	TANKS:

Date of last physical exam Have you had X-rays taken? O No O Yes What medications are you taking and for what What vitamins, minerals, or herbs do you curren		sage and amour	nts, etc)I	Yes requency).	
s. marinis, minorais, or norse do you coner	III) ICKET II ICCSC IISI IOI W	Tier conditions, d	osago, ana n	oquericy).	
Have you ever:	No Yes Brie	fly Explain			61.45
Broken bones? Been hospitalized? Been in an auto accident? Had Sprains/Strains? Been struck unconscious? Had surgery?	000000				
Do you experience pain every day? Do your symptoms interfere with daily life? Does pain wake you up at night?					No O Yes No O Yes No O Yes
Are your symptoms worse during certain to Do changes in weather affect your sympton Do you wear orthotics? Do you take vitamin supplements? What activities aggravate your symptoms	oms?			10	No O Yes
Habits		None	Light	Moderate	Heavy
Alcohol Coffee Tobacco Drugs Exercise Sleep Appetite Soft Drinks Water Salty Foods Sugary Foods Artificial Sweeteners		000000000000000000000000000000000000000	000000000000000000000000000000000000000	000000000000000000000000000000000000000	000000000000000000000000000000000000000

O Yes

Medical History

Have you been treated for any conditions in the last year? O No

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)	Date
Parent, Guardian or Patient's legal representativ	ve
Signature THIS FORM WILL BE PLACED IN THI	E PATIENT'S CHART AND MAINTAINED
FOR SIX YEARS.	le to whom you authorize the Practice to release

Seminole Chiropractic Wellness Center Dr. Randal L. Butch

This office is committed to providing patients with quality health care services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapist, staff and patient working together as a team to obtain maximum results. Patient satisfaction is a vital interest to our staff. This facility is required by law to abide by the terms of the Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Below is our Informed Consent, please sign and date the bottom of the page.

Informed Consent

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of procedure(s) which the doctor/provider feels at the time is in my best interest. I understand and informed that, as in the practice of medicine, as in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. Treatment may include but not limited to chiropractic adjustments, chiropractic procedures, physical therapy, and diagnostic x-ray.

As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedure(s) we recommend including but not limited to rest, exercises, home applications of therapy, and/or referral to a medical/surgical specialist.

Patients have the right to refuse treatment, but must be aware of the probable consequence of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Any supplemental recommendations that are mentioned are simply nutritional and herbal support for someone with said noted condition and someone without said noted condition. Please be advised that any suggested nutritional, herbal and dietary advice is not intended as a primary treatment or therapy for any disease or particular bodily symptom. The nutrition and herbs recommended are provided solely to support the normal physiological processes of the human body.

I hereby give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider at this facility.

Print Name of Patient	
Signature of Patient (if minor, parent or legal guardian must sign	Date

Seminole Chiropractic Wellness Center Dr. Randal L. Butch

Consent for Open Treatment Area and Permission to Share Patient Information

I understand that Seminole Chiropractic Wellness Center may leave a phone message in the effort and if necessary to obtain or provide information regarding appointments, and account occurrences. In addition, I also understand that Seminole Chiropractic Wellness Center may send postcards and billing statements to the address listed on file.

Further more, I understand that Seminole Chiropractic Wellness Center uses an open treatment area where conversations between the patient and the doctor and/or staff may be overheard by other patients and facility members. If at any time the patient does not feel comfortable, he or she may ask the doctor and/or staff to be put in a closed treatment area.

By signing the line below, I give full consent to Seminole Chiropractic Wellness Center to mail post cards and billing statements to the address listed on file.

Check all that apply:		
	y be left on Home Phone	Cell Phone Work Phone
Phone messages	may be left with Persons living	in my home
Phone messages	regarding appointments may be	e left with coworkers
Information regarding m	y treatment may be discussed v	with the following individuals:
1.		
Name	Relationship	Phone Number
2.		
Name	Relationship	Phone Number
Information regarding m	y treatment may NOT be discu	issed with the following
individual:		
1.		
Name	Relationship	Phone Number
Z. Name	Relationship	Phone Number
Name	Relationship	Phone Number
may rayoka this Consent/A	thorization at any time. A suritten result	ocation which will not be effective until
received and approved by the		vocation which will not be effective until
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Patient Signature/Guard	lian/Authorized Representative	Date

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT/CLIENT RIGHTS

- 1. The right to obtain information, about his/her condition, in terms he/she can understand.
- 2. To make informed decisions regarding your care planning, and offer suggestions on how we may improve our service/care.
- 3. To have your pain assessed as it relates to the service provided.
- 4. The right to considerate and respectful care.
- 5. To agree to or refuse any part of the plan of service or plan of care.
- 6. The right to continuity of care.
- The right to privacy and confidentiality of medical condition and medical records.
- 8. The right to examine and receive an explanation of his/her bill.
- 9. The right to file a grievance.
- 10. The right to know the rules and regulations, of the company, that apply to his/her responsibility as a patient/client.
- 11. To obtain service without regard to race, creed, national origin, sex, age, disability or illness, or religious affiliation.
- 12. To have your communication needs met.

PATIENT/CLIENT RESPONSIBILITIES

- To supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered.
- 2. The responsibility to provide correct and complete information.
- 3. To ask questions regarding, your individualized, Plan of Treatment which you do not understand.
- 4. To arrive, in a timely manner, for scheduled appointments or notify us in advance to make other arrangements.
- 5. The responsibility to comply with instructions.
- 6. To take responsibility for the outcome when refusing treatment.
- 7. The responsibility to fulfill financial obligations.
- 8. The responsibility to be respectful and considerate to those providing them with care.

Complaints and Concerns

If you are concerned that Seminole Chiropractic Wellness Center may have violated your privacy rights or if you disagree with any decisions we made regarding access or disclosure of your personal health information, please contact our Privacy/ Security officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. Seminole Chiropractic Wellness Center will not tolerate any retaliatory acts against anyone who files a complaint. For further information of Seminole Chiropractic Wellness Center health information practices, or if you have a complaint, please contact the following:

Randal Butch
Privacy/Security Officer
Seminole Chiropractic Wellness Center
8229 113th St. North
Seminole F.L. 33772
Phone: 727.398.3999

none: 727.398.399 Fax: 727.397.3777

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Signature:	Date:	