**Patient Name**: **Birth date**:\_\_\_/\_\_\_/\_\_\_

List all prescription, non-prescription **medications** and other supplements you take as well as the associated condition:

List any **surgeries** or **hospitalizations** you have had complete with the month and year for each:

List anything you are **allergic** to:

**Family History** (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases   
and the relation to you of the individual):

Are you here because of an **accident**? What type?

**HIPAA & Authorization to Release**

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. I understand that should I need a more detailed account of my policy and procedures concerning the privacy of my Patient Health Information, I am welcome to read the HIPAA Notice that is available at the front desk before signing this consent. Copayments, coinsurance, and/or deductibles are due at time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of estimation. There is a 2 hour time period for any missed appointment. No notice of a missed or late appointment within the 2 hours will result in a $25 no call/no show fee.

In Order for our office to provide ANY information to your Spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-Rays, receipts, Insurance Information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

*My information may be shared with: (List Names and relationship to patient)*

Patient’s Signature: Date: \_\_\_/\_\_\_/\_\_\_