NEW PATIENT FORM

Dr Erick Bingham

Utah Valley Chiropractic

In order to understand your needs
we encourage you to fill out the following information for our records.

This document was designed so that you can easily type your information in the boxes listed below; then save it on your computer, email it, print it, fax it, or drop it by when you visit. Also if you have any comments or questions about this form please feel free to call us at …

(801) 796 9512 *Fax*

(801) 922 4310 *Phone*

559 West State Road, Pleasant Grove, UT 84062

DocBingham@Yahoo.com *Email*

Please Save Document if you are Typing Information in Boxes

How did you Find Us? (please fill in one of the three choices below) (or just type yes in the box)

Referred by who ... Sign or Business Card ... GOOGLE search or FACEBOOK ...

Today's Date: / 20 File#_____ (filled in by office)

Your Name: Female Male

What do you prefer to be called

Birthday: _/_/_ Age: SS: - -

Home Address:

(Street Address)

(City) (State) (Zip Code)

Home Phone #: ( ) - Other Phone #: ( ) -

Employer:

Employer's Address:

(Street Address)

(City) (State) (Zip Code)

Occupation: Phone# ( ) -

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name:

Referred To This Office By:

Who Is Responsible For Your Bill, You and:

Spouse Worker's Comp Auto Insurance Medicare Parents

In Event of Emergency: Name Relationship

Home#: ( ) - Other#:( ) -

Who is your Primary Physician: Phone# ( ) -

Insurance Company's Name: Phone#: ( ) -

Insurance Company's Address:

Insurance Company Name:

(Street Address)

(City) (State) (Zip Code)

Group #: Policy #:

Insured's Name: Insured SS#: - -

Relation: Date of Birth - -

Are you covered under any other group or individual health policy through yourself or spouse?

Yes No (If YES), Company's Name:

Insurance Companies Phone # ( ) -

Insured's Address:

Insured's Name:

(Street Address)

(City) (State) (Zip Code)

Group #: Policy#:

Insured's Name: Insured SS#: - -

Relation Date of Birth - -

PLEASE READ THE FOLLOWING CAREFULLY

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made. If account is not paid within 30 days of the date of service and no finical arrangements have been made, you will be responsible for legal fees, collection fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, and assign all insurance benefits directly to the provider.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Printed Name:

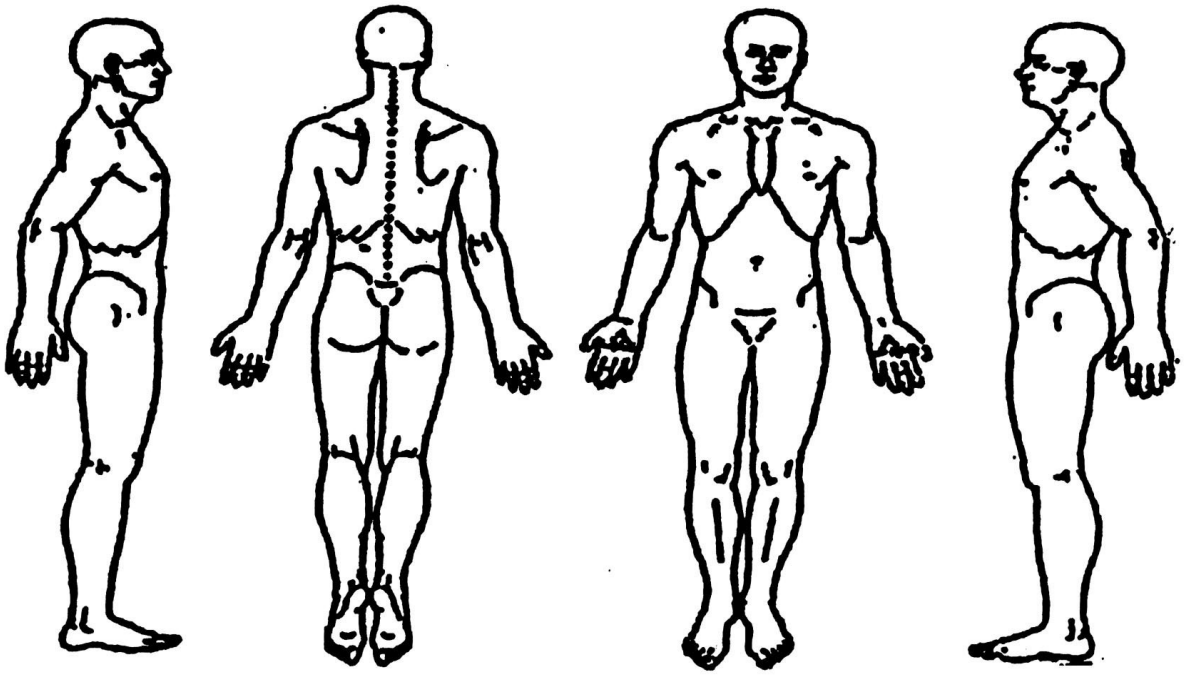
Signature Date: / 20

PATIENT INTAKE FORM pg. 1

Patient Name: _____ **Date:** _____ / _____ **20** _____

Please indicate with a [Y] in the boxes provided to identify the problem

1. **Is today's problem caused by:** [ ] Auto Accident [ ] Workman's Compensation
2. **Indicate on the drawings below where you have pain/symptoms (please mark after you print).**



3. **How often do you experience your symptoms?**

[ ] Constantly (76-100% of the time) [ ] Occasionally (26-50% of the time)
[ ] Frequently (51-75% of the time) [ ] Intermittently (1-25% of the time)

PATIENT INTAKE FORM pg. 2

Patient Name: _____ **Date:** _____ / _____ **20** _____

4. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other please explain: _____

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(*Please check Y next to number)*

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other: _____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

How long have you had this problem?

_____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

PATIENT INTAKE FORM pg. 3

Patient Name: _____ **Date:** _____ / _____ **20** _____

15. What is your: Height _____ **Weight** _____ **Age** _____

Occupation _____

16. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Cancer ☐ ALS

19 a. For each of the conditions listed below, place a p **in the box to represent "PAST" conditions**

If you presently have a condition listed below, place C **in the box to represent "CURRENT" conditions**

Leave blank ☐ **if you have NOT had the condition in the PAST or CURRENTLY**

(mark all that apply)

☐ Loss of Appetite

☐ Headaches	☐ High Blood Pressure	☐ Diabetes
☐ Neck Pain	☐ Heart Attack	☐ Excessive Thirst
☐ Upper Back Pain	☐ Chest Pains	☐ Frequent Urination
☐ Mid Back Pain	☐ Stroke	☐ Smoking/Tobacco Use
☐ Low Back Pain	☐ Angina	☐ Drug/Alcohol Dependence
☐ Shoulder Pain	☐ Kidney Stones	☐ Allergies
☐ Elbow/Upper Arm Pain	☐ Kidney Disorders	☐ Depression
☐ Wrist Pain	☐ Bladder Infection	☐ Systemic Lupus
☐ Hand Pain	☐ Painful Urination	☐ Epilepsy
☐ Hip Pain	☐ Loss of Bladder Control	☐ Dermatitis/Eczema/Rash
☐ Upper Leg Pain	☐ Prostate Problems	☐ HIV/AIDS
☐ Knee Pain	☐ Abnormal Weight Gain/Loss	☐ Ankle/Foot Pain

PATIENT INTAKE FORM pg. 4

Patient Name: _____ **Date:** _____ / _____ **20** _____

19 b. For each of the conditions listed below, place a p **in the box to represent "PAST" conditions**

If you presently have a condition listed below, place C **in the box to represent "CURRENT" conditions**

Leave blank _____ **if you have NOT had the condition in the PAST or CURRENTLY**

(mark all that apply)

		For Females Only
____ Jaw Pain	____ Abdominal Pain	____ Birth Control Pills
____ Joint Pain/Stiffness	____ Ulcer	____ Hormonal Replacement
____ Arthritis	____ Hepatitis	____ Pregnancy
____ Rheumatoid Arthritis	____ Liver/Gall Bladder Disorder	
____ Cancer	____ General Fatigue	
____ Tumor	____ Muscular Incorrdination	
____ Asthma	____ Visual Disturbances	
____ Chronic Sinusitis	____ Dizziness	
____ Other:	_____	

20. List all prescription medications you are currently taking:

_____

_____

_____

21. List all of the over-the-counter medications you are currently taking:

_____

_____

_____

22. List all surgical procedures you have had:

_____

_____

_____

PATIENT INTAKE FORM pg. 5

Patient Name: _____ **Date:** _____ / _____ **20** _____

23. What activities do you do at work?

_____	**Sit:**	_____ Most of the day	_____ Half the day	_____ A little of the day
_____	**Stand:**	_____ Most of the day	_____ Half the day	_____ A little of the day
_____	**Computer work:**	_____ Most of the day	_____ Half the day	_____ A little of the day
_____	**On the phone:**	_____ Most of the day	_____ Half the day	_____ A little of the day

24. What activities do you do outside of work?

_____

_____

25. Have you ever been hospitalized? _____ No _____ Yes

if yes, why _____

Have you had significant past trauma? _____ No _____ Yes

26. Anything else pertinent to your visit today?

_____

Patient Signature _____ **Date:** _____ / _____ **20** _____

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.

Medical Information Disclosure Form pg. 1

Patients Name (Print please)

Patient Initials _____ Date: ____ / ____ ***20*** ____

In the course of your care as a patient at Utah Valley Chiropractic we may use or disclose personal and health related information about you in the following ways:

-Your protected health information, including 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, and HMO, PPO , or your employer, if they are or may responsible for the payment of services provided to you.

-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, or the health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contact. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

-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.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

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.

Medical Information Disclosure Form pg. 2

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 specific form please advise us in writing as to your preferences.

You have the right to inspect and /or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

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 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.

If you have a complaint, or if you would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should contact:

Dr. Erick Bingham (801) 922-4310

Privacy/Security Officer

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 4, 2011. This notice, and any alterations of amendments made hereto will expire seven years after the date upon which the patient record was created. My signature acknowledges that I have received a copy of this notice.

Patients Name (Print please) _____

Patient Signature_____ **Date:** _____ / _____ **20** _____

If you are a minor, or if you are being represented by another party ☐ Yes ☐ No

Personal Representative (Print please) _____

Signature_____ **Date:** _____ / _____ 20 _____

Description of the authority to act on behalf of the patient

TERMS OF ACCEPTANCE

This document constitutes informed consent for chiropractic services.

When a patient seeks Chiropractic health care, and we accept that patient for such care, it is essential for both to be working towards the same goal. This prevents confusion and disappointment.

A *vertebral subluxation* is a mechanical interference by the spinal bones to the transmission of energy and information over nerve pathways.

The only goal of this office is to keep the body as free from vertebral subluxations as possible. This is due to our absolute conviction that every human being functions better on all levels when fewer vertebral subluxations are present.

We do not offer to examine, diagnose, treat or give advice about any disease or condition, whether physical, mental, or emotional other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care who specializes in that area.

It is the responsibility of each individual to keep us informed and updated regarding any accidents, injuries, surgeries, illnesses, medication, or other factors that could relate to the safety of receiving our services.

I have read and understand the above statements. All question pertaining to my receiving Chiropractic services in this office have been answered to my complete satisfaction.

Patients Name (Print please) _____

Signature_____ **Date:** _____ / _____ **20** _____

Complete if patient is a minor child

I, being the parent or legal guardian of the above minor, have read and fully understand the above terms of acceptance. I hereby grant permission for him/her to receive straight chiropractic services at this office.

Legal Guardian or Parents (Print please) _____

Guardians or Parents Signature_____ **Date:** _____ / _____ **20** _____

PATIENT AUTHORIZATION REGARDING CHIROPRACTIC CARE BEING AN "OPEN-DOOR" ADJUSTING ENVIRONMENT

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally 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 is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

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. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Erick Bingham or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Patients Name (Print please) _____

Signature _____ **Date:** ____ / ____ 20 ____

If you are a minor, or if you are being represented by another party, please provide the appropriate person's:

Full Name (Print please) _____

Signature_____ **Date:** ____ / ____ **20** ____

_____

Relationship to the patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.