Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____

I am (circle) Under Age 18/Single/Married/Divorced/Widowed/Separated #Of Children_____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell Email Address: _____

I was referred to this office by: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer_____ Spouse's Phone_____

Emergency Contact: _____Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Dr. Robert J. Reier, P.A. to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr. Robert J. Reier, P.A. and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

CHIEF COMPIAINT FORM

NAME_____ DATE_____

WHAT IS YOUR MAIN COMPLAINT TODAY?

_____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HOW DID THIS CONDITION BEGIN?_____

_____

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION BETTER? _____

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION WORSE? _____

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS BETTER? _____

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS WORSE? _____

HAS YOUR CONDITION BEEN CONSTANT OR DOES IT COME AND GO? _____

HAVE YOU SEEN ANY OTHER HEALTH CARE PRACTITIONER FOR THIS CONDITION? IF SO, WHO AND WHEN?

_____

_____

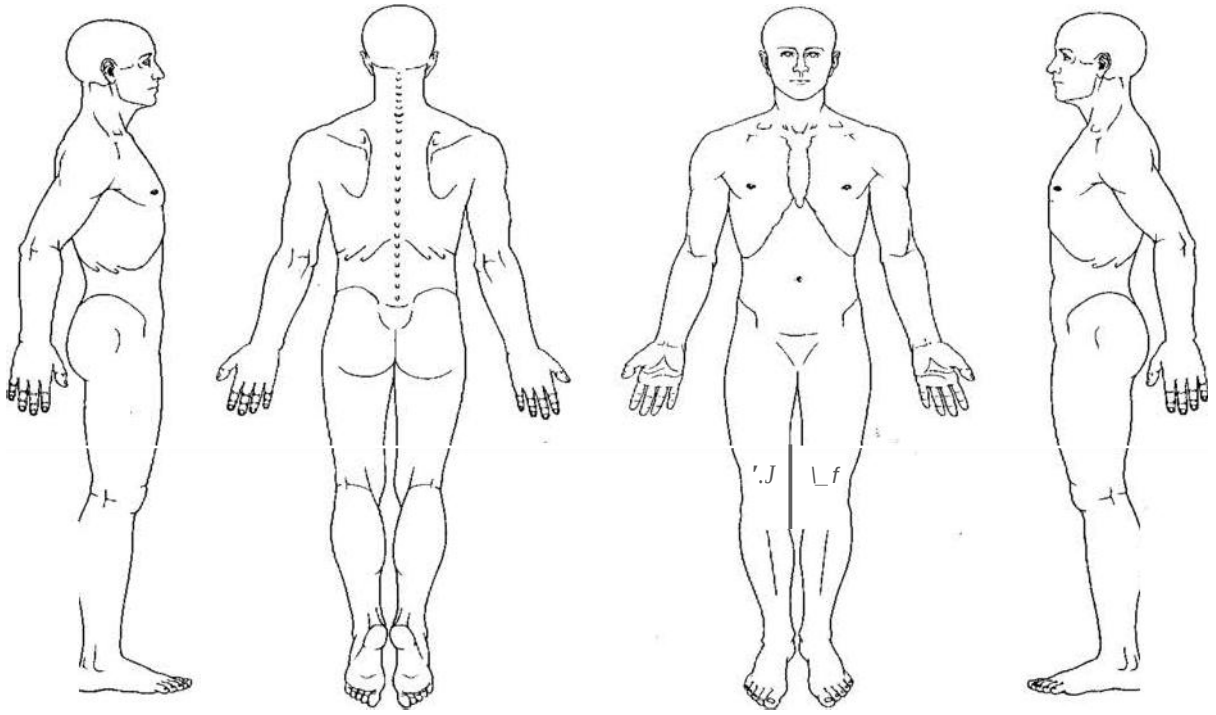
IF THERE IS PAIN INVOLVED, ON A SCALE OF 1 – 10 (10 BEING THE WORST POSSIBLE PAIN YOU CAN THINK OF), HOW WOULD YOU RATE THIS PAIN?

RIGHT NOW _____/10 **WORST POINT** _____/10 **BEST POINT** _____/10

IS THIS PAIN/SENSATION? (PLEASE CIRCLE)

SHARP STABBING DULL ACHY THROBBING TINGLING STIFF BURNING NUMB

PLEASE INDICATE THE AREA OF COMPLAINT (IF APPLICABLE):



Health Questionnaire

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder	○	○
Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control	○	○
Allergies Headache	○	○	Excessive thirst	○	○	Low back pain	○	○
Angina	○	○	Frequent Urination	○	○	Mid back pain	○	○
Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain	○	○
Arthritis	○	○	Hand pain	○	○	Painful Urination	○	○
Asthma	○	○	Heart attack	○	○	Prostate Problems	○	○
Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain	○	○
Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use	○	○
Cancer	○	○	Hip/upper leg pain	○	○	Stroke	○	○
Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus	○	○
Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome	○	○
Depression	○	○	Jaw pain	○	○	Tumor	○	○
Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer	○	○
Dizziness	○	○	Kidney Stones	○	○	Upper back pain	○	○
Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain	○	○

List all prescription, non-prescription medications and other supplements you take:

_____

_____

_____

_____

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

_____

_____

_____

List any injuries, traumas, (i.e. car accidents, falls, etc.):_____

_____

_____

List anything you are allergic to: _____

Family History (List all major diseases such as cancer, diabetes, heart problems, bone/joint diseases):

_____

_____

Do you exercise? ○Yes ○No Hours per week _____ What activity(s)? _____

_____

Are you dieting? ○Yes ○No Since: _____ Do you smoke? ○Yes ○No If yes, _____ packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? ○Yes ○No ____drinks per day/week.

Do you wear? ○ Heal lifts ○ Arch supports ○ Prescription Orthotics

For women: Are you pregnant or nursing? ○ Yes ○ No If pregnant, how many weeks? _____

***Important* Do you have a pacemaker? ○ Yes ○ No**

Additional comments you would like the doctor to know: _____

_____

_____

_____

_____

Patient's signature: _____ Date: _____

Doctor's signature: _____ Date: _____

Doctor Notes:

_____

_____

_____

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_____

Dr. Robert J. Reier
Chiropractic • CARE of Bel Air

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410-893-2600

HIPAA-Notice of Privacy

Dear Patient,

Welcome to the office! We are honored you have chosen this office to provide chiropractic care to you and/or your family. Be assured that we will do everything in our power to give you a very positive experience. Our aim is to get you well and help you meet *your* health goals…period. Our office mission and guarantee:

"If we can help you, we will tell you. If we cannot help you, we will tell you that as well and make the proper referral."

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

- **Treatment**
- **Payment**
- **Health Care Options**
- **Advice of Appointments and Services**
- **Directory/Sign-In Log**
- **Court Orders, Subpoenas and Government Investigations**
- **Advise Family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.**

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPAA compliance.

I understand that by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these right available through the HIPAA officer at this location.

_____Signature
_____ Date

If you ever need anything, just ask one of our staff or call me directly at 410-893-2600. I'd love your feedback on how we are doing in terms of meeting, hopefully exceeding your expectations so that you will refer your friends, family, and co-workers. The greatest compliment we can receive is the trust placed in us via your referrals. We value that trust! Again, welcome to the office.