



Dr. Robert J. Reier

# Chiropractic CARE of Bel Air

*Evidence Based . . .  
Results Driven*

## Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    First                                    MI                                    Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I am (circle) Under Age 18/Single/Married/Divorced/Widowed/Separated    Number of Children \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

## How Did You Hear About Our Practice?

Were you referred by your physician or other health care provider?  Yes  No    If yes, please list the provider's name:

Were you referred by a family member or friend?  Yes  No    If yes, who may we thank for referring you to our practice? \_\_\_\_\_  
Other Referral Source: \_\_\_\_\_

## 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 COMPLAINT 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?

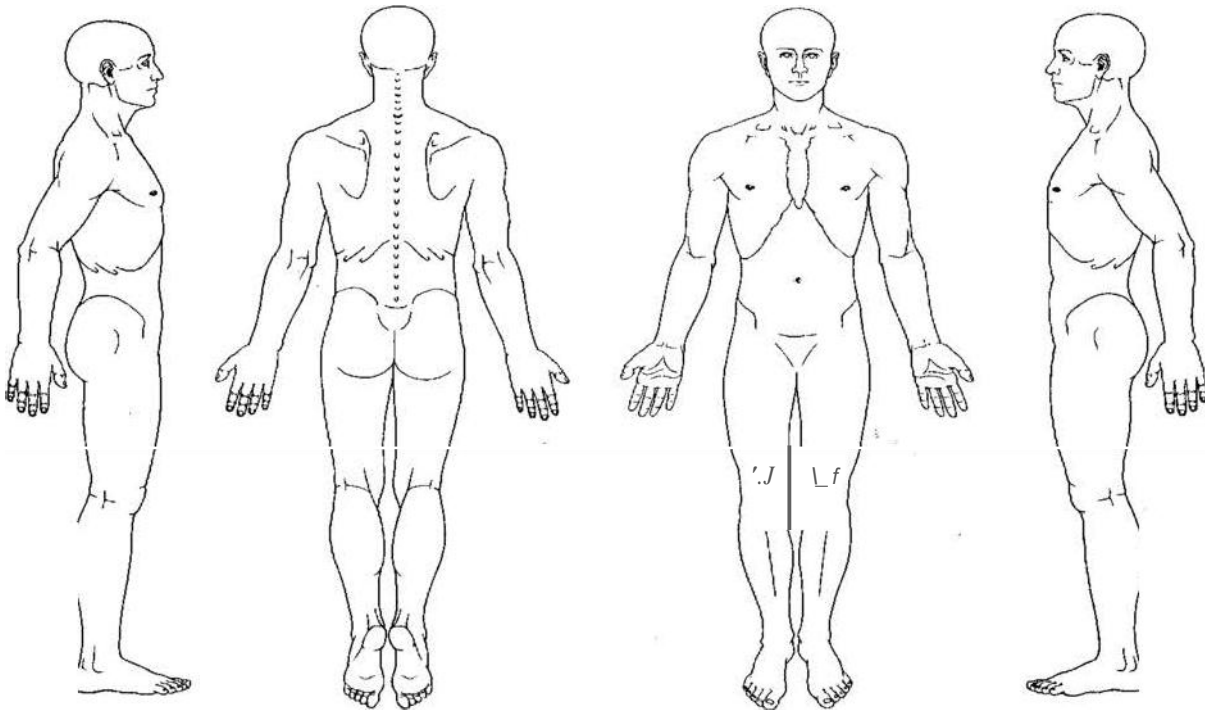
IF THERE IS PAIN INVOLVED, ON A SCALE OF 1 – 10 (10 BEING THE WORST POSSIBLE PAIN YOU CAN THINK OF), HOW WOULD YOU RATE THIS PAIN?

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

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

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

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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?  Heel 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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\_\_\_\_\_

## **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.