# Patient Information

Last _____ First_____ Date of Birth_____ Age_____

Address _____
Street or PO Box City State Zip Code

Home Phone _____ Cell Phone_____ Email_____

Social Security #_____ Ethnicity_____ Sex: M / F Marital Status: S M D W

Employer_____ Occupation_____ Work Phone_____

Spouse Name_____ Employer_____ Work Phone_____

## IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Parent name_____ Cell Phone_____ Alternate Phone_____

Parent name_____ Cell Phone_____ Alternate Phone_____

Responsible Party _____ Birth Date_____ SSN_____

Address if Different_____
Street or PO Box City State Zip Code

## INSURANCE INFORMATION******PLEASE PROVIDE CARD SO THAT WE MAY MAKE A COPY******

**Insurance #1**_____ Name of Insured_____

Relationship to Patient_____ Birth Date_____ SSN_____

**Insurance #2**_____ Name of Insured_____

Relationship to Patient_____ Birth Date_____ SSN_____

If over 18 can we contact your parent listed above to discuss financial information? _____ YES _____ NO

Is this an accident that occurred during school sports? YES / NO if yes, Date_____

Have you been injured on the job? YES / NO If yes, Date_____ If yes, who is your employer? _____

If accident, is there an attorney involved? YES / NO If yes, attorney name_____

Is this condition a pre-existing condition or a medical condition existing at a time when new insurance is applied for, for which treatment is not covered by the insurance? YES or NO

In case of emergency, please notify_____ Relationship_____ Phone #_____

Who referred you to this practice? _____ Primary Care Provider _____

## Assignment of Insurance Benefits

I hereby authorize assignment of my medical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my Chiropractor, **Timothy Melton, DC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____
Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial_____

# Tim Melton, DC

# 4601 Buffalo Gap Rd. Suite C-1

# Abilene, TX 79606


## AUTHORIZATION FOR CHIROPRACTIC CARE

I, the undersigned, a patient in this office, hereby authorize Dr. Tim Melton to administer such treatment as is necessary, and to perform therapy and adjustment and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand that AUTHORIZATION FOR CHIROPRACTIC CARE, the reason why the above treatment is considered necessary, its advantages and possible complication if any, as well as possible alternative modes of treatment, which was explained to me by Dr. Melton.

I certify that no guarantee of assurances have been made as the result that may be obtained.

Patient Signature_____

Date_____

*****I ALSO UNDERSTAND THAT ANY CARE RENDERED AFTER NORMAL BUSINESS HOURS WILL HAVE AN ADDITIONAL FEE THAT IS NOT COVERED UNDER MEDICARE, WORK COMP, OR OTHER HEALTH PLANS. THE INDIVIDUAL IS ULTIMATELY RESPONSIBLE FOR THIS ADDITIONAL FEE. *****

Tim Melton, DC

# Release of Protected Health Information HIPPA

**My Protected Health Information may be released to the following person(s)**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***If you would like anyone other than yourself to be able to call our office and to discuss your account or medical information you must print his/her name in the space provided. This does include spouses.**

***If patient is a student athlete, can private health care information be discussed with the school's certified athletic trainer? YES or NO**

In order to ensure that you receive comprehensive and quality healthcare, do you consent to have your medical records sent to any of your **primary care doctors or specialists on record? YES or NO**

I hereby authorize my physician Tim Melton, DC to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the **insurance, Medicare, or any other health plan or its agents,** any information needed to determine these benefits or the benefits payable to related services. **YES or NO**

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

## Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

I have reviewed this office's Notice of Privacy Practices from Tim Melton, DC, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial _____

**Tim Melton, DC**

**Chiropractic First Visit & Medical History**

Name_____ Date_____

Age _____ Height_____ Weight_____

Reason for visit? _____

When did it your symptoms appear? _____

Is this condition getting progressively worse? YES: _____ NO: _____ Unknown:_____

Rate the Severity of your pain: **Pain Scale:** 0 1 2 3 4 5 6 7 8 9 10
(No pain) (Worst pain)

**Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting**
**Burning Tingling Cramps Stiffness Swelling**

Other?: _____

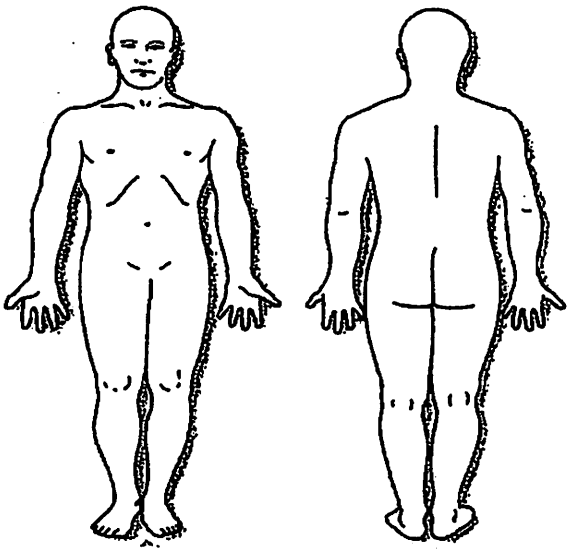
How often do you have this pain? _____

Is the pain constant in nature or does it come and go?_____

Does it interfere with your?: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

**Mark on the diagram where you are having the following symptoms:**
Pain: XXX Numbness: OOO Tingling: /////



# Medical History Form

Name: _____ Age: _____ Date of Birth: _____

**What pharmacy do you use to fill medications?** _____

**Medications and dosages:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Allergies/Reactions:**

_____ _____ _____

_____ _____ _____

## Past Medical History

**Do you have or have you had any of the following medical conditions? *(Please circle)***

| | | | |
|---|---|---|---|
| Cancer | Kidney Disease | Blood Disorders | Diabetes |
| Bladder problems | Neurological Disorders | High Blood Pressure | Urinary Tract |
| Infections | Stomach Ulcers | Stroke | Liver Disease |
| Heart Attack | Hepatitis | Tuberculosis | Gout |
| Heart Disease | Emphysema/ COPD | Pacemaker | Congestive Heart Failure |
| Asthma | Depression | Anxiety | Thyroid Problems |
| HIV/AIDS | High Cholesterol | Osteoporosis | Psychiatric disorder |
| Arthritis | Rheumatoid Arthritis | Headaches | |

Other: _____

## Surgical History

**Have you had any of the following surgical procedures? *(Please circle and include dates)***

Back Surgery _____

Neck Surgery _____

Knee Surgery _____

Shoulder Surgery _____

Heart Surgery _____

Other: _____

## Family History

**Does anyone in your family suffer from any of the following medical conditions? (Please circle)**

| | | | |
|---|---|---|---|
| Cancer | Kidney Disease | Blood Disorders | Diabetes |
| Bladder problems | Neurological Disorders | High Blood Pressure | Urinary Tract |
| Infections | Stomach Ulcers | Stroke | Liver Disease |
| Heart Attack | Hepatitis | Tuberculosis | Gout |
| Heart Disease | Emphysema/ COPD | Pacemaker | Congestive Heart Failure |
| Asthma | Arthritis | Depression | Anxiety |
| HIV/AIDS | High Cholesterol | Osteoporosis | Thyroid Problems |
| Arthritis | Rheumatoid Arthritis | Headaches | Psychiatric disorder |

Other: _____

## Social History

**Are you:** Married Single Divorced Widowed

**Do you smoke?** YES or NO Packs per day _____

**Do you drink alcohol?** YES or NO Drinks per week _____

**Are you working?** YES or NO Job Description: _____ **Are you on restrictions?** Yes or NO