**Dr. Heidi Boehm Ware, D.C.** **Dr. Kimberly Anderson, D.C.**

Date: _____

**Patient Information: (Please answer all questions that apply to you)**

**Last Name: _____ First Name: _____ M.I._____S.S.#_____**

Address:_____

City/State:_____Zip:_____

Phone #s: Home: _____Cell:_____Work:_____

Email Address:_____

Birthdate:_____Sex: M or F Marital Status: S___M___D___W___ Height____ Weight___

Occupation:_____
Employer:_____Address:_____Zip:_____
Referred By:_____How Did You Hear About Us?_____

What is your major complaint?_____
How long have you had this condition?_____
Other doctors who have treated you for this?_____
List Surgeries:_____
FEMALE ONLY: Is there any chance that you are pregnant? YES[ ] NO [ ]

**INSURANCE INFORMATION**

Primary Insurance Company (Please Present Cards):_____
Other Insurance (Secondary Health Coverage, Auto Policy, or Work Comp:_____
[ ] NO INSURANCE
Is Condition Related to (Circle One) Work Accident, Auto Accident
*Additional paperwork required, please ask receptionist for form(s)*
Please Describe Briefly:_____

INSURED'S NAME:_____RELATIONSHIP TO INSURED:_____
Date of Birth:_____S.S#:_____
Address if Not Same as Above:_____Zip:_____
City/State:_____Work Address:_____
Zip:_____City/State:_____Phone:_____

Patients Name: _____

## PATIENT HISTORY

**Please check Any that apply:**

[ ] Headache
[ ] Double Vision
[ ] Irritability
[ ] Anxiety
[ ] Tension
[ ] Depression
[ ] Fatigue
[ ] Dizziness
[ ] Fainting
[ ] Nausea/Vomiting
[ ] Equilibrium Problems
[ ] Pain Behind Eyes
[ ] Difficulty Lifting
[ ] Difficulty in Rising to Walk after Sitting
[ ] Upper Back Pain
[ ] Mid Back Pain
[ ] Neck Pain
[ ] Neck Stiffness
[ ] Pain Radiating into Neck
[ ] Pain While Sitting
[ ] Pain While Walking
[ ] Pain While Standing
[ ] Leg Pain (L or R)
[ ] Numbness in Feet
[ ] Restriction of Motion
[ ] Low Back Pain
[ ] Difficulty in Walking
[ ] Chest Pain
[ ] Shortness of Breath
[ ] Numbness in Arms
[ ] Numbness in Legs
[ ] Swelling
[ ] Excessive Perspiration
[ ] Tremors
[ ] Sinus Trouble
[ ] Neuritis
[ ] Cold Feet
[ ] Cold Hands
[ ] Difficulty Bending
[ ] Difficulty in Standing

### Family Health Information

Please give details of any family health conditions (e.g. hypertension, heart problems, diabetes, back problems, cancer, etc.)

Name: Relation: Past/Present Health Problems:

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**Assignment**

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

**Release of Information**

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case, and hereby release this clinic of any consequence thereof.

**Financial Responsibility**

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

**Patient Privacy Policy**

By signing below I acknowledge that I have received Boehm-Ware, and Anderson Chiropractic's privacy policy and understand my agreement to its terms.

I certify that I have read and agree to the above terms:

Patient Signature: _____ Date: _____

Guardian/Parent Signature Authorizing Care:_____ Date:_____

**Dr. Heidi Boehm Ware, D.C.** **Dr. Kimberly Anderson, D.C.**

Patient's Name:_____

Preferred method of communication for patient reminders (Circle One) Email / Phone / Mail

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS *requires providers to report both race and ethnicity*

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications and/or supplements? (Please include regularly used over the counter medications)

| Medication/Supplement Name | Dosage & Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Case History

Yes No
[ ] [ ] Have any of your relatives had diabetes?
[ ] [ ] Has your weight changed in the past year more than 10 LBS?
[ ] [ ] Have you ever been addicted to drugs or alcohol?
[ ] [ ] Have you ever been turned down for life insurance?
In the Past Five years have you:
[ ] [ ] Been Treated or examined by a doctor?
[ ] [ ] Had an X-ray or any laboratory test or study?
[ ] [ ] Had Observation or treatment in a hospital?
[ ] [ ] Had a surgical operation?
Have you ever had:
[ ] [ ] Epilepsy, Nervous breakdown or other nervous disorder?
[ ] [ ] High blood pressure, dizziness, or heart trouble?
[ ] [ ] Tuberculosis or any respiratory disorder?
[ ] [ ] Ulcer, indigestion or other disorder of the digestive tract?
[ ] [ ] Sugar in the urine or problems with urination?
[ ] [ ] Diabetes, gout, goiter or other glandular disorders?
[ ] [ ] Diseases of the eyes, ears, skin muscles or bones?
[ ] [ ] Cancer or Tumor?
[ ] [ ] Any condition not listed above?

Boehm family Chiropractic

50 Filer Street • Suite 216 • Manistee, MI 49660 • (231) 723-2221

# HIPAA Disclosure Form

**Patient Name:**_____ **Date:**_____
**Address:**_____
_____
**Current Phone Number:**_____ **DOB:** _____
**Email Address:**_____

**Appt. Reminders: May we contact you via text messaging? ( )Yes ( )No**
**If YES, Phone number to receive messages:** _____
**If we need to call you may we identify ourselves over the phone? ( )Yes ( )No**
**May we leave a message? ( )Yes ( )No**
**( ) I do not wish to be contacted regarding my upcoming appointments.**
***We require 24hr notice to cancel or reschedule appts to avoid incurring a fee.***

**Emergency Contact :** _____ **Phone:**_____

**I, the patient, hereby authorize Boehm Family Chiropractic to release my medical information (appointments, x-ray results, and/or treatments) via postal mail or telephone to the following family members.**

| Name | DOB | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

**Reminder:** This document once signed by patient is good for 1 year. Patient has the right to update this form as often as needed. If the patient did not list you on this form, we cannot discuss any medical information with you.

_____

Signature Date