

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:

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

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:

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: _____

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? |



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

HIPPA Disclosure Form

Patient Name: _____	Date: _____
Address: _____	

Current Phone Number: _____	DOB: _____
Email Address: _____	
When Contacting you:	
May we identify ourselves over the phone? () Yes () No	
May we leave a message? () Yes () No	

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