

HESTERA CHIROPRACTIC

PATIENT INFORMATION & HEALTH HISTORY

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

D.O.B. _____ E-Mail Address _____

Age _____ Sex: Male / Female Single Married Widowed Divorced

Occupation _____

Employer _____

Home Phone _____ Work Phone _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

Insurance Information:

PLEASE LET OUR STAFF PHOTOCOPY YOUR INSURANCE CARD

Insurance Co. _____

Name of Insured _____

****ASSIGNMENT AND RELEASE****

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ insurance company and assign directly to Dr. David J. Hestera, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charge whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ *Date* _____

PATIENT'S CURRENT CONDITION:

Please describe your reason for today's visit:

HEALTH HISTORY

Have you ever seen a chiropractor before? Yes No

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Date of 1st treatment _____ Number of treatment(s) in last 12 months _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____ Chest X-ray _____

Urine Test _____ Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Please check symptoms you currently have:

- Balance impairment Headaches Loss of Memory Vertigo
- Burning Eyes Lightheadedness Nausea Visual/Sensory Disturbance
- Depression Loss of Concentration Ringing/Buzzing in Ears

Please check conditions or symptoms you currently have or have had in the past:

- AIDS/HIV Cataracts Herniated Disk Parkinson's Disease Tuberculosis
- Anemia Chemical Dependency Herpes Pinched Nerve Tumors, Growths
- Anorexia Diabetes High Blood Pressure Pneumonia Ulcers
- Appendicitis Emphysema High Cholesterol Polio Varicose Veins
- Arthritis Epilepsy Jaw Pain/TMU Prosthesis Whiplash
- Asthma Glaucoma Kidney Disease Psychiatric Care Other _____
- Blood Clots Goiter Liver Disease Rheumatoid Arthritis _____
- Breast Lump Gout Mononucleosis Rheumatic Fever _____
- Bronchitis Heart Disease Multiple Sclerosis Scarlet Fever _____
- Bulimia Hepatitis Osteoporosis Stroke _____
- Cancer Hernia Pacemaker Thyroid Problems _____

EXERCISE	WORK ACTIVITY	LIFESTYLE
<input type="checkbox"/> None <input type="checkbox"/> Daily	<input type="checkbox"/> Sitting <input type="checkbox"/> Light Labor	<input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Coffee/Caffeine Cups/Day _____
<input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<input type="checkbox"/> Standing <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Accidents/Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/SUPPLEMENTS

MEDICATION TAKING FOR

HESTERA CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic on this basis.

Signature

Date

Hestera Chiropractic

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Hestera Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive.

Hestera Chiropractic will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

Hestera Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Hestera Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research health and safety, governmental functions, in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Dr. David Hestera and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Hestera Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used or disclosed, accommodate reasonable requests you may make to your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr. David Hestera at 720.898.5353.

Patient Signature

Date