# Patient Update Form

Date: _____

First Name _____ MI _____ Last Name _____ DOB _____ Age _____
Street _____ Apt _____
City _____ State _____ ZIP _____

SSN _____ Marital Status: S M D W Other _____ Spouse's name: _____

**Contact Info:** Home Ph: _____ Work Ph: _____ Cell Ph: _____
Email _____
**Contact Preference:** ___Home Phone ___Work Phone ___Cell Phone ___Email ___Postal Mail

**Language** __English __Spanish __French __Chinese __German __Other _____

**Race/Ethnicity** __American Indian or Alaska Native __White __Black or African American __Other __Hispanic or Latino __Decline to Answer

Occupation: _____ Employer: _____
Employer Address: _____
Street City State ZIP Phone/Fax Number(s)

Emergency Contact _____ Relationship _____ Phone: _____

Who may we thank for referring you to our office? _____ Phone: _____

**Insurance Information:** If there have been ANY changes that you know of or think might be changes on your insurance, please inform the receptionist and allow us to make new copies of your cards so we can call, verify and update your files.

**Patient History:**
Please give a brief description of the problem(s) you are experiencing and/or reason for seeking chiropractic care:

_____
_____
_____

**Vitals:** Height _____ Weight _____ ((for office use only) Blood Pressure _____ Pulse _____)

**Medications:**

| Type | Brand Name | Dosage | Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies:**

| Type | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Surgeries:**

| Date | Type of Surgery | Result |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Hospitalization:**

| Date | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please check any Major Illnesses you have had in the past:**

___High or Low Blood Pressure (circle one)

| | | | | |
|---|---|---|---|---|
| ___Broken or Fractured Bones | ___Osteoarthritis | ___Eating Disorder | ___Circulatory Problems | ___Epilepsy |
| ___Rheumatoid Arthritis | ___Alcoholism | ___Pace Maker | ___Excessive Bleeding | ___Strokes |
| ___Seizures/Convulsions | ___HIV Positive | ___Cancer | ___Drug Addiction | ___Ruptures |
| ___A Congenital Disease | ___Depression | ___Ulcers | ___Gall Bladder | ___Coughing |

**Family History:** Father, Mother, Brother, Sister, GM, GF
**(use F, M, B, S, GM or GF to all that apply)**

Deceased _____
Cause of death _____

| | | |
|---|---|---|
| *Tuberculosis___ | *Cancer_____ | *Mental Illness_____ |
| *Asthma_____ | *Kidney ____ | *Heart Disease_____ |
| *Diabetes_____ | *Stroke_____ | *Lung Disease_____ |
| *Arthritis | *Other | *Liver Disease |

**Social History:** (please check all that apply)

| Exercise | Habits | |
|---|---|---|
| __None | __Smoking | Packs/Day_____ |
| __Moderate | __Alcohol | Drinks/Week___ |
| __Daily | __Coffee/Caffeine | Cups/Day_____ |
| __Heavy | __High Stress Level | Reason_____ |

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. I ;you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before singing this consent.

1) The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3) A patient's written consent need only be obtained one time for all subsequent care give at the patient in this office.

4) The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient Name

_____ _____

Patient (Legal Guardian) Signature Date