Louro Chiropractic Center
Confidential New Patient Information

Name: _____
Address: _____
City/State/Zip: _____
Phone: Home _____ Cell _____ Work _____
D.O.B. _____ Age: _____
Who may we thank for referring you? _____
Occupation: _____ Employer: _____
Sex: M / F Single / Married / Divorced / Widowed
Spouse's Name: _____
Email: _____

Primary reason for this visit: _____

_____

Do you exercise? NO / YES How often? _____
What type: _____
Rate your diet: Healthy __ Average __ Poor __ Do you use supplements YES NO
Type _____
Alcohol: Never / Rare / Moderate / Daily
Smoker? NO / YES ____ # Packs/day since year: ___ Past Smoker? NO / YES
Previous chiropractic care? YES / NO
If yes, Dr.'s Name _____ Last Visit

_____

Other doctors you are currently seeing:

_____

Current medications:

_____

Over the counter drugs taken in the past 3 months:

_____

List all surgeries:

_____

_____

List all accidents and falls:

_____

_____

Primary Insurance_____
ID _____
Policy Holder_____ Birthday_____

Secondary Insurance_____
ID _____
Policy Holder_____ Birthday_____

Patient signature_____ Date_____

HEALTH HISTORY FORM

Patient's Name_____ Date____/____/___

If you are NOT experiencing ANY symptoms, please go to Section B: Health History

Section A: Current Problem

Date of Onset: _____ Cause of Condition (if known)_____
How often during the day do you experience this?
___ 0-25% ___ 25-50% ___ 50-75% ___ 75-100%

Describe the pain: ___ sharp ___ dull ___ achy ___ stiff ___ shooting ___ burning ___ spasm
How severe is this problem? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme
Since the onset, is the pain? ___ worse ___ better ___ same ___on & off
Is there anything that makes it worse? ___ standing ___ sitting ___ lying down ___ motion
Is there anything that makes it better? ___ standing ___ sitting ___ lying down ___ motion
Is this problem? ___ Better or ___ Worse ___ AM or ___ PM ___ Neither
Are any systems involved? ___ Digestive ___ Cardiovascular ___ Respiratory ___Reproductive
Does the pain cause you to?
___ Lose sleep ___ Be short tempered ___ Miss work ___ Miss play ___ Lose focus
What has this problem kept you from enjoying?

_____
Have you had a similar condition in the past? Y N If yes, explain:
What treatment(s) have you already had for this problem?
Medication Surgery Physical Therapy Chiropractic None
Other:_____
What was the outcome of this treatment?_____
_____
Any other facts about your current problem
_____
_____
_____
Is there any chance you could be pregnant? YES NO Date of last menstrual period_____

- Section B: Health History (Please check if you have had or are currently experiencing any of the following:)

Anxiety	Anemia	Arthritis	Thyroid Problems	Bowel Problems
Cancer	HIV/AIDS	Tuberculosis	High Blood Pressure	Heart Trouble
Diabetes	Hepatitis	Insomnia	Venereal Disease	Muscular Dystrophy
Epilepsy	Dizziness	Convulsions	Multiple Sclerosis	Rheumatic Fever
Neuritis	Asthma	Scarlet Fever	Digestive Problems	Sinus Trouble
Allergies	Backaches	Numbness	Frequent Colds	Nervousness
Stroke	Depression	Headaches	Cold Hands/Feet	Restless Sleep
Ulcer	Irritability	Impulsivity	Low Pain Threshold	Fibromyalgia
Hernia	PMS	Bruising	German Measles	Osteoporosis
Nausea	Swelling	Mood Swings	Chronic Fatigue Syndrome	Infertility

Describe other details about Your Past Medical History:_____

_____

_____

_____

_____

Section C: Family History (Your Blood Relatives Only)

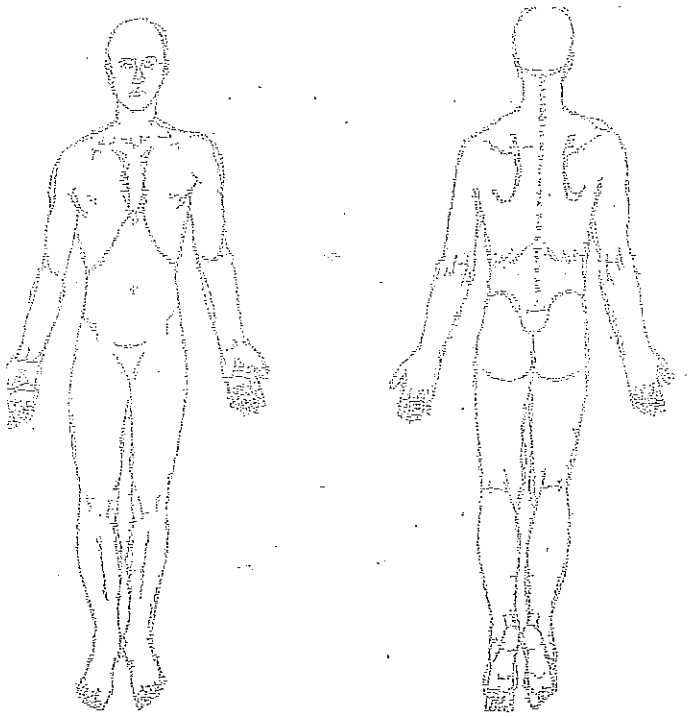
☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Thyroid Problems ☐ Stroke ☐ Multiple Sclerosis

☐ Other:

_____

_____

Please mark on the picture, where you have any problems.



Patient/Guardian Signature_____ Date:_____

Louro Chiropractic Center

Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: Final Rule as seen in Federal Register 2/20/2003

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

_____ _____

Signature Date

Louro Chiropractic Center

180 N. County Line Rd
Jackson, NJ 08527
(732) 928-5900

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

_____ _____

Signature Date

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

_____ _____

Signature Date

LOURO CHIROPRACTIC CENTER

HIPPA RELEASE FORM

PATIENT NAME _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed by name individually including a spouse or significant other.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health information and account balances.

_____

Name Relationship phone#

_____

Name Relationship phone#

_____

Name Relationship phone#

Signature_____ Date _____

Louro Chiropractic Center

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

Signature _____ Date _____

Financial Obligations

The patient accepts full financial responsibility for services rendered by this practice. Payment in full required for all services rendered at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses included in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Deductibles

Any charges that are applied toward your deductible will be your responsibility.

Referrals

You are responsible for obtaining a valid referral if required from your primary physician. It is your responsibility o keep track of how many visits are approved on your referral.

Signature _____ Date _____