Patient Information

Legal First Name: _____ MI: _____ Last Name: _____

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: S M W D Spouse: _____

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____
French _____ German _____ Russian _____ Other _____

Race: White _____ American Indian or Alaska Native _____ Asian _____ Hispanic or Latino _____
Native Hawaiian/Other Pacific Islander _____ Black or African American _____
Decline to Answer _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to Answer _____

DOB: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier _____

Please check your contact preference: Hm _____ Wk _____ Cell _____ Email _____ Mail _____ Text Msg _____

Email Hm: _____ Email Wk: _____

Occupation: _____ Employer: _____

Employer Address: _____

Emergency Contact: _____ Phone Number: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____

_____

_____

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been diagnosed with Diabetes? Type I____or Type II_____	□	□	_____
...been treated for hypertension?	□	□	_____

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Height:_____ Weight:_____ Average Blood Pressure (if known):_____

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible

_____

_____

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication List Type of Allergy and Reaction

_____

_____

_____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____

Major Complaint Information

Date _____

Name you prefer:_____ How did you hear about BaxPlus?_____

What is your major complaint(s)? _____

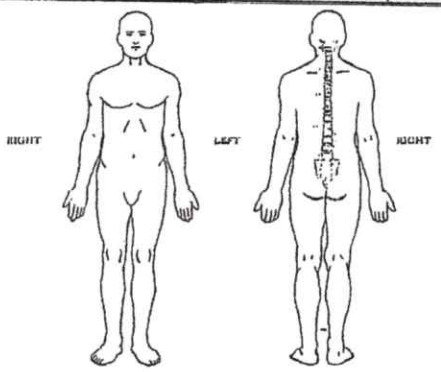
_____

When did this symptom(s) begin? _____

Describe what happened_____

Did these symptoms develop from? ☐ Auto Accident ☐ Work-Related Injury
Have you reported this to your: insurance company? ☐ Yes ☐ No employer? ☐ Yes ☐ No

Mark your areas of pain using the Pain Index on the right.



Pain Index

P	Pain
B	Burning
St	Stabbing
S	Sharp
C	Constant

On a scale of 1-10 (1 being best, 10 being worst), please circle how bad the pain is when you feel the worst.

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ☐ Yes ☐ No When? _____

What makes this condition feel worse? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? ☐ Yes ☐ No Doctor's Name: _____
Date consulted: _____ Diagnosis:_____

Does this condition interfere with your sleep? ☐ Yes ☐ No
If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ☐ Back ☐ Side ☐ Stomach

Have you tried a heating pad? ☐ Yes ☐ No How does it affect the pain? _____

Have you tried a cold pack? ☐ Yes ☐ No How does it affect the pain? _____

Do you wear a heel lift? ☐ Yes ☐ No if so, which side? ☐ Right ☐ Left

Does it cause pain to cough, grunt or sneeze? ☐ Yes ☐ No If so, where? _____

Name of family physician: _____ Phone # _____

If female, are you pregnant? ☐ Yes ☐ No ☐ Not sure If yes, what is your due date: _____

Please check the activities that aggravate your complaint.

____ Lying on Back	____ Getting in/out of car	____ Sleeping	____ Stooping	____ Standing for periods
____ Lying on side with knees bent	____ Gripping	____ Pushing	____ Sitting	over one hour
____ Turning over in bed	____ Climbing	____ Pulling	____ Bending forward	____ Sneezing
____ Lying flat on stomach	____ Dressing self	____ Reaching	____ Bending backward	____ Coughing
	____ Kneeling	____ Walking		

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No Please List:

Type of Hospitalization/Surgery: _____ Date: _____ Type of Hospitalization/Surgery: _____ Date: _____

_____ _____ _____ _____

Have you ever been seen by a chiropractor before? ☐ Yes ☐ No Please List:

Name of chiropractor: _____ Date: _____ Name of chiropractor: _____ Date: _____

Fill out the next three sections as they apply to you.

Headaches

Do you have a family history of headaches? ☐ Yes ☐ No Do you get headaches? ☐ Yes ☐ No Frequency _____

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No ☐ High ☐ Low Nausea, Vomiting or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1-6 months ☐ 6-12 months ☐ 1-2 years ☐ over 2 years Results: _____

Lower Back

Do you ever experience ripping or tearing sensations in your back? ☐ Yes ☐ No If so, where? _____

Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No Explain: _____

Neck

If you have a neck injury, does it affect: (Check all that apply) ☐ hearing ☐ vision ☐ balance ☐ cause ringing in your ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Do you feel ripping or tearing? ☐ Yes ☐ No Where? _____

Do you have difficulty lifting or turning your head? ☐ Yes ☐ No If so, in which direction? ☐ Right ☐ Left ☐ Up ☐ Down

Please check all additional complaints that you have at this time.

- ☐ Headache
- ☐ Loss of Concentration
- ☐ Eyes Sensitive to Light
- ☐ Memory Loss
- ☐ Heavy Feeling of Head
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Pain Behind Eyes
- ☐ Fainting
- ☐ Palpitation
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Motion Restricted
- ☐ Upper Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Lower Back Pain/Stiffness
- ☐ Right/Left Shoulder Pain
- ☐ Right/Left Arm Pain
- ☐ Right/Left Leg Pain
- ☐ Pins & Needles Arms/ Legs
- ☐ Vision Problems
- ☐ Sinus Trouble
- ☐ Nervousness
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Loss of Consciousness
- ☐ Irritable
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Fatigue
- ☐ Flushed Face
- ☐ Excess Perspiration
- ☐ Digestive Trouble
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Jaw Pain
- ☐ Cancer
- ☐ Hypertension
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Convulsions
- ☐ Allergies (Please List)

_____

_____

_____

- ☐ Anemia
- ☐ Heart Disease
- ☐ Arthritis
- ☐ HIV (Aids)
- ☐ Other (Please List)

_____

_____

_____

Please Specify Location:

- ☐ Numbness _____
- ☐ Swelling _____
- ☐ Cuts _____
- ☐ Bleeding _____
- ☐ Broken Bones _____
- ☐ Bruising _____

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No
If so, please list : _____

Any additional information you would like the doctor to know about before beginning care at Baxplus? _____

_____

_____

BaxPlus Chiropractic

PATIENT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice or if you need more information, please contact:

BaxPlus
Attn: Dr. Don Wagner
10 Copperfield Circle
Lititz, PA 17543

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at **BaxPlus.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI:

Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minors to their parents or guardians unless such disclosure is otherwise prohibited by law.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Abuse, Neglect, or Domestic Violence. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out:
Individuals Involved in Your Care. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Payment for Your Care. Unless you object in writing, you can exercise your rights under HIPAA that your health care provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

Your Rights, Subject To Certain Limitations, Regarding Your PHI:
Inspect and Copy. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care.

Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

Paper Copy of This Notice. You have the right to a paper copy of this notice.

Changes to This Notice:
We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future.

Notice Effective 8/7/17

BAXPLUS CHIROPRACTIC
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **BaxPlus** Patient Notice of Privacy Practices effective August 7, 2017.

Patient Signature:_____(or Guardian, if applicable) Date:_____