FIRST CHOICE CHIROPRACTIC
INJURY & WELLNESS CENTER
Welcomes You

Patient Information

Date _____

Patient: _____

Patient prefers to be called: _____

Address: _____

City _____ State _____ Zip _____

Northern Address: _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Spouse's Name: _____

I give your office permission to discuss my medical information with the following individuals:

Name _____ Relationship _____

Phone#: _____

Name _____ Relationship _____

Phone#: _____

Insurance

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____ _____ _____

Relationship to Patient: _____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____ _____ _____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, Certify that I or my dependent, have Insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hearby 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.

Signature _____

Phone Numbers

Home: ___, _____ Work ___, _____ Ext_____

Cell: ___, _____ EMAIL:_____

May we leave medical information on your answering machine or cell phone: ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Phone#: _____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Work Comp ❑ Other

Attorney Name (If applicable) _____

_____

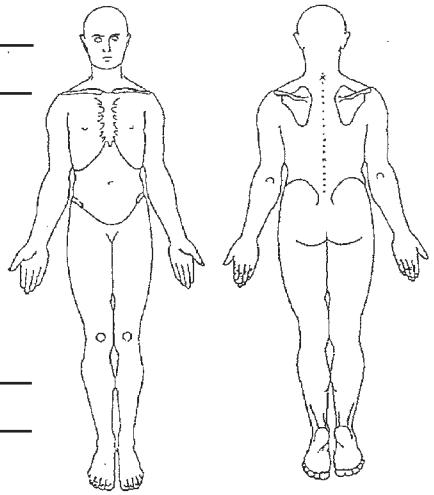
Patient Condition

Reason for visit _____

When did symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your... ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

Health History

What treatment have you already recieved 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 Last:

Physical Exam _____ Dental X-Ray _____ Chest X-Ray _____ Blood test _____

Spinal Exam _____ Spinal X-Ray _____ MRI, CT scan, Bone scan _____ Urine test _____

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Habits
- ☐ Smoke - pks/day_____
- ☐ Alcohol - drinks/wk _____
- ☐ Coffee/Caffeine drink - cups/day_____
- ☐ High Stress - reason_____
- ☐ OTHER_____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Medications	**Allergies**	**Vitamins, Minerals, Herbs**

Injuries / Surgeries	**Date**	**Description**
☐ Falls		
☐ Head Injuries		
☐ Broken Bones		
☐ Dislocations		
☐ Surgeries		

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	**Emphysema** ☐ Yes ☐ No	**Migraine headaches** ☐ Yes ☐ No	**Rheumatic fever** ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	**Epilepsy** ☐ Yes ☐ No	**Miscarriage** ☐ Yes ☐ No	**Scarlet fever** ☐ Yes ☐ No
Allergy shots ☐ Yes ☐ No	**Fractures** ☐ Yes ☐ No	**Mononucleosis** ☐ Yes ☐ No	**Stroke** ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	**Glaucoma** ☐ Yes ☐ No	**Multiple sclerosis** ☐ Yes ☐ No	**Suicide Attempt** ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	**Goiter** ☐ Yes ☐ No	**Mumps** ☐ Yes ☐ No	**Thyroid problems** ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	**Gonorrhea** ☐ Yes ☐ No	**Osteoporosis** ☐ Yes ☐ No	**Tonsillitis** ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	**Gout** ☐ Yes ☐ No	**Pacemaker** ☐ Yes ☐ No	**Tumors/growths** ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	**Heart disease** ☐ Yes ☐ No	**Parkinson's disease** ☐ Yes ☐ No	**Typhoid fever** ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No	**Hepatitis** ☐ Yes ☐ No	**Pinched nerve** ☐ Yes ☐ No	**Ulcers** ☐ Yes ☐ No
Breast lump ☐ Yes ☐ No	**Hernia** ☐ Yes ☐ No	**Pneumonia** ☐ Yes ☐ No	**Vaginal infection** ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	**Herniated disk** ☐ Yes ☐ No	**Polio** ☐ Yes ☐ No	**Venereal disease** ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	**Herpes** ☐ Yes ☐ No	**Prostrate problem** ☐ Yes ☐ No	**Whooping cough** ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	**High cholesterol** ☐ Yes ☐ No	**Prosthesis**	**Other** _____
Cataracts ☐ Yes ☐ No	**Kidney disease** ☐ Yes ☐ No	**Psychiatric care** ☐ Yes ☐ No	_____
Chemical dependency ☐ Yes ☐ No	**Liver disease** ☐ Yes ☐ No	**Rheumatoid Arthritis** ☐ Yes ☐ No	_____
Chicken pox ☐ Yes ☐ No	**Measles** ☐ Yes ☐ No		_____
Diabetes ☐ Yes ☐ No			

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Brett M. Herrington, D.C., P.A.
Lic #CH7510 • NPI #1013904648
PHONE: (727) 535.7799
FAX: (727) 535.3638
2575 Harn Blvd.
Clearwater, FL 33764
drbrettdc.com

CONSENT FOR TREATMENT

PATIENT NAME _____

To the Patient:

Please read this entire document before signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. This may cause an audible "pop" or "click", as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis, Examination, Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

✓ spinal manipulative therapy	✓ radiographic studies	✓ hot/cold therapy
✓ range of motion testing	✓ palpation	✓ vital signs
✓ muscle strength testing	✓ orthopedic testing	✓ basic neurological testing
✓ ultrasound	✓ postural analysis	✓ EMS

____ Other

_____

_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

CONSENT FOR TREATMENT (continued)

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for when taking your history, x-rays and performing your examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self administered, over-the-counter analgesics and rest.
- Medical care and perscription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant in remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ☐ or **have had read to me** ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed treatment concerns with Brett M. Herrington, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I have been informed of the risks.

I hereby give my consent to that treatment.

DATE	**DATE**
PATIENT NAME (please print)	**DOCTOR NAME (please print)**
PATIENT SIGNATURE	**DOCTOR SIGNATURE**
SIGNATURE of PARENT or GUARDIAN (if a minor)	

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FINANCIAL POLICY

PLEASE READ CAREFULLY

First Choice Chiropractic Injury & Wellness Center will bill a maximum of two insurance carriers on behalf of the patient with the understanding that the final responsibility for payment of the account rests with the patient. Although FCC will bill a maximum of two insurance carriers, and works closely with the patient regarding the settlement of liability claims, it is done so only as a convenience to the patient in settling his/her account. First Choice Chiropractic Injury & Wellness Center's filing of the insurance claims on the patient's behalf does not relieve the patient of the final responsibility for settling his/her account.

Our doctors are Medicare participating.

All payments for deductible, co-insurance, and non-covered services are due at the time of service.

I completely understand and will comply with the above information.

PATIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

_____

PATIENT NAME (PLEASE PRINT)

_____

SIGNATURE

_____ _____

PARENT, GUARDIAN, OR PATIENT'S LEGAL REPRESENTATIVE **DATE**

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX (6) YEARS.