PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ______________ Zip ______________

Sex ☐ M ☐ F Age ______________

Birthdate ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

INSURANCE INFORMATION

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (______) __________ Home Phone (______) __________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________ Relationship ______________

Home Phone (______) __________ Work 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 ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________________

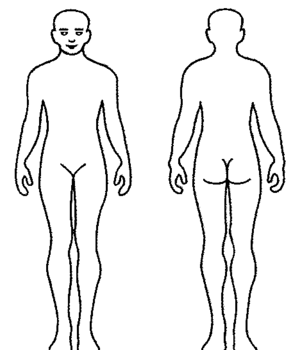
PATIENT CONDITION

Reason for Visit ______________________

When did your 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 constant 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 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 Last: Physical Exam ____________ Spinal X-Ray ____________ Blood Test ____________

Spinal Exam ____________ Chest X-Ray ____________ Urine Test ____________

Dental X-Ray ____________ MRI, CT-Scan, Bone Scan ____________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ 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 Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ____________		
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No			

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ____________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ____________

Are you pregnant? ☐ Yes ☐ No Due Date ____________

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name ____________		
Pharmacy Phone (____) ____________		

Barry L. Cole, DC, FADP
Doctor of Chiropractic

417 Troy Avenue
Dyersburg, TN 38024
Phone: (731) 285.2696
Toll Free: (800) 558.2696
Fax: (731) 285.2701
e-mail: coleclinic@yahoo.com
www.colechiropracticclinic.com

Date: ________________ **Time:** ___________**A.M./P.M.**

CONSENT TO PREFORM X-RAYS AND TO TREAT

I have been informed by Dr. Barry L. Cole that diagnostic x-rays are advisable in my case in order to make a proper diagnosis of my musculoskeletal problem. These x-rays may or may not be covered by my insurance. I also give Dr. Barry L. Cole to administer whatever treatment is deemed necessary to treat my present condition. **INITIAL:** ___________________

I give Dr. Barry L. Cole permission to take the proper x-rays and treat my child.
INITIAL: _________________________

To the best of my knowledge I am **NOT PREGNANT** and I request x-rays to be taken for diagnostic interpretation. **INITIAL:** _____________________

I give Dr. Barry L. Cole permission to show my x-rays for educational purposes.
INITIAL: __________________

VERBAL AUTHORIZATION AGREEMENT

I give Cole Chiropractic Clinic permission to contact me or my family on my home, cell or work telephone regarding my treatment and/or scheduling of appointments. Chiropractic information and updates can be sent to my email address.
EMAIL: _________________________ **INITIAL:** _______________

PROTECTED HEALTH INFORMATION
&
RIGHTS & RESPONSIBILITIES

I have received and reviewed the Notice of Privacy Practices for Protected Health Information from Cole Chiropractic Clinic. **INITIAL:** _____________________

____
Patient Name   Date

____
Patient/Parent/Legal Guardian Signature   Date

____
Witness Signature   Date

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Authorization for Release of Information

I, ______________________________, hereby authorize _____________

__________________________ too release my Medical Records and X-rays to Dr. Barry L. Cole D.C. FADP

A photocopy of this authorization shall be considered effective and valid as the original. This release is effective for 2 years.

Patient Signature: ____________________________ Date: ____________

Date of Birth: _______________________ SS# ______________________

Witness Signature: ___________________________ Date: ____________

COLE CHIROPRACTIC CLINIC

OFFICE POLICIES

1) Please be on time for your appointment. Being late, or last minute cancellations will cause scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2) Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems, and strong scents can impair their progress.
3) Continued cancellations or missed appointments may result in being released from care.
4) Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will assist you with your well-behaved children.
5) We may schedule you for multiple appointments. This will help insure convenient appointment times for you, as well as provide you with the highest level of care possible.
6) If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.
7) Please notify your doctor of **ANY** changes in your health status, regardless of the significance.

FINANCIAL POLICIES

1) Payment is expected at the time of the visit.
2) We accept the following forms of payment: Cash, Check, Debit or Credit Card. There is a returned check fee of $20.00.
3) We also offer a personalized payment plan which allows you to start treatment today and spread the payments over time. Arrangement for payment and scheduling will be completed and signed prior to initial intensive care.
4) We will bill your primary insurance company as a courtesy to you. You must pay your deductibles and co-pays as charges incur.
5) The patient is **ALWAYS** responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
6) Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.
7) The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due will be charged a service charge 18%APR.
8) Any account where no payment has been received for ninety days will be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient.
9) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
10) Your insurance company determines when they receive our billings. Any statements made by our staff regarding your coverage in no way or guarantees that your care here will be covered by your insurance company, and you be responsible for your account, regardless of insurance.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or Legal Guardian: ______________________________ Date: __________

Witness: ______________________________________ Date: __________