New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name ______ Last Name ______ Date ______ Email* ______

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address ______ City ______ State ______ Zip ______

Telephone (Cell) ______ (home) ______ Referred By ______

Age ______ Birth Date ______ Social Security # ______ Number of Children ______

Occupation ______ Employer ______

Marital Status ______ Spouse's Name ______ Spouse's Occupation ______

Spouse's Employer ______ Spouse's Health Status ______

Emergency Contact ______ Phone ______

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe: ______

Date of Injury ______ Date symptoms appeared ______

Have you ever had same condition? ○ No ○ Yes If yes, when? ______

List of other practitioners seen for this injury/condition ______

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe ______

Insurance Information

Name of party responsible for payment ______ Phone ______

Do you have health insurance? ○ No ○ Yes Name of company ______

*** If an auto accident, please provide:**

Insurance Company Name ______ Contact Person ______

Phone: ______ Claim # ______

Signatures

Name of the insured ______

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ______ Date ______

Spouse's or guardian's signature ______ Date ______

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)l

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

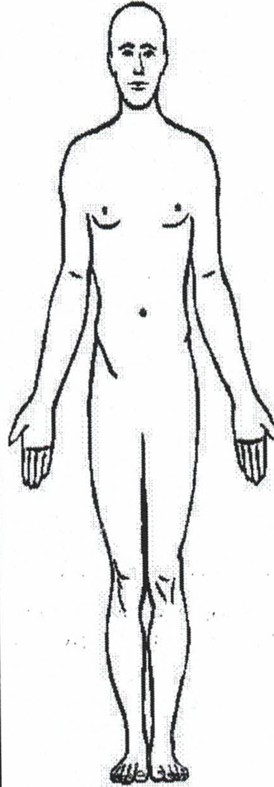
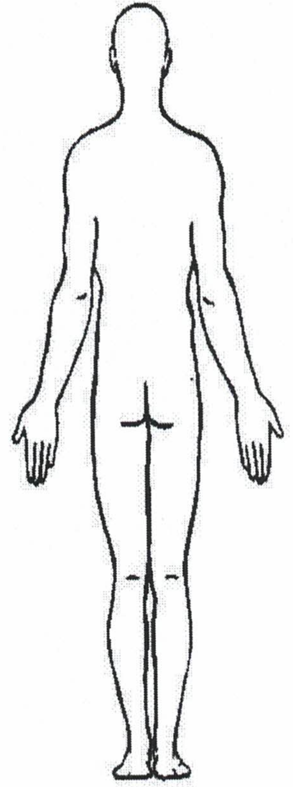
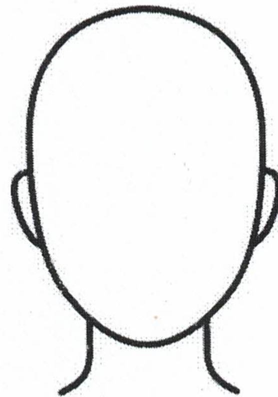
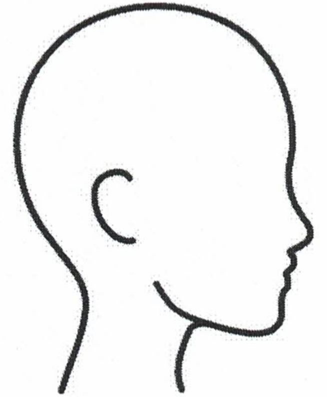
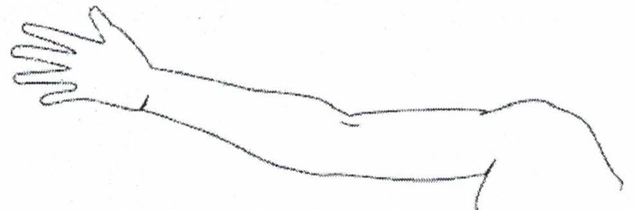
Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

Have you ever suffered from:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/Conditions
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ears Ring
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Loss of memory
- [ ] Loss of balance
- [ ] Loss of smell
- [ ] Loss of taste
- [ ] Lumps In Breast
- [ ] Neck Pain or Stiffness
- [ ] Nervousness
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Sciatica
- [ ] Shortness of breath
- [ ] Sinus Infection
- [ ] Sleep problems or Insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other: ____________

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing

CITY LINE CHIROPRACTIC One Presidential Blvd, Suite 203 Bala Cynwyd, PA 19004 610-617-7300

AUTHORIZATION AND RELEASES

Consent for Treatment

I, the undersigned, hereby authorize Dr. Seward and whomever he may designate as his assistant (s) to perform diagnostic tests including but not limited to radiographs and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand agree that health and accident insurance policies are an arrangement 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 my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. 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.

Patient Signature ________________________________ Date ___/___/___ Witness ____________________

Authorization to Release Medical Information

I authorize Dr. __________________________ to release any medical information pertinent to my treatment plan to City Line Chiropractic or an authorized representative for review. The authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient Signature ________________________________ Date ___/___/___ Witness ____________________

Request for Payment of Benefits to Provider of Care

I hereby authorize the ________________________________ Insurance Company / Insurance Administrator to pay by check and for it to be mailed directly to One Presidential Blvd, Suite 203 Bala Cynwyd, Pa 19004 the expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient Signature ________________________________ Date ___/___/___ Witness ____________________

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my attorney _________________________________, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the Doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the Doctor's interest, the Doctor will not await payment but will require me to make payment on a current status.

Patient Signature ________________________________ Date ___/___/___ Witness ____________________

Consent for Treatment of Minor

I hereby authorize Dr. Seward and whomever he may designate as his assistant(s) to perform diagnostic tests including, but not limited to, radiographs and to administer treatment as he deems necessary to my (indicate relationship of child) ________________________ (child's name) __________________________

Guardian's name _______________________________ Date __/__/__ Witness________________________

X-ray / Medical Records Release

I have requested the release of records of (patient name) _______________________________ which are a part of the records at (Facility) ____ (Address) _________________________________ I hereby authorize you, your employees and agents to furnish to the person (s) listed below, or anyone designated in writing by them, all copies of records and reports including copies of X-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to (Name) ____

____

Patient Signature ________________________________ Date ___/___/___ Witness ________________________

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and other patients with the best optimal spinal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request that you please notify our office in advance if you are unable to make your scheduled appointment. Effective March 14th, 2022, if you neglect to notify the office at least 24 hours before your appointment time that you will be unable to make your appointment, a $40.00 no call/ no show fee will be charged to your card on file. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office.

__________________________________ SIGNATURE

____________ DATE

NO CELL PHONE USE IN TREATMENT AREA

Although we know that cell phone use is sometimes necessary, **our policy is that no cell phone is to be used in our waiting area, especially in the treatment areas (i.e. hyrdrobed, STM unless it is an emergency.** We ask that you respect this policy due to all of our patients, including you, needing this time to heal and focus on relaxing so that the healing process can take place. Also, cell phone use can be extremely disturbing to other patients so please respect this policy. Thank you.

__________________________________ SIGNATURE

____________ DATE

FEE FOR COPY OF XRAY CD

Should you require a copy of your x-ray CD, whether you have an injury case (i.e. Auto, Work Comp, etc.) or you see us as a cash patient or through your insurance, the fee for us to provide any patient with a copy of their x-ray CD is $10. Thank you.

__________________________________ SIGNATURE

____________ DATE

DOCTOR'S NOTES NEEDED

Should you need a doctor's note for missing work/school/other, you must give no less than 2 hours notice prior to needing a doctor's note. Otherwise, a doctor's note will not be provided to you until the next business day.

__________________________________ SIGNATURE

____________ DATE

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 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 and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing 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.
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 obliged to agree to those restrictions.
3. A patient's written consent needs only be obtained one time for all subsequent care given to 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 have been trained in 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 ensure 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.

____
Signature of Patient

____
Date