

**ONTARIO CHIROPRACTIC  
PATIENT HEALTH INFORMATION**

Date: \_\_\_\_\_

**PATIENT INFORMATION:**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_

Emp. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: Married Single Widowed Divorced

Referred by: \_\_\_\_\_

**Demographic Information**

Sex: Male Female

Race: White Native American / Alaskan Asian  
African American Pacific Islander Other

Ethnicity: Hispanic / Latino Not Hispanic / Latino  
Other

**SPOUSE INFORMATION:**

Spouse's Name: \_\_\_\_\_ MI: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

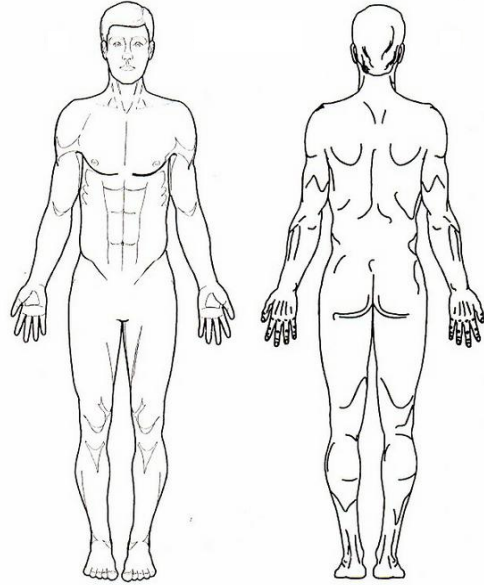
Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone : \_\_\_\_\_

Please mark your areas of pain on the figure below.



**GUARANTOR INFORMATION FOR MINOR:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Social Sec. #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_

Emp. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bus. Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:**

*I hereby authorize the doctor to administer chiropractic care as deemed necessary to:*

\_\_\_\_\_  
(provide dependent's name & relationship to you)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**HEALTH INFORMATION**

Have you had previous chiropractic care? \_\_\_\_\_ If yes, who did you see, and when? \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

Have you had this or similar conditions in the past? Yes No Is this condition getting progressively worse? Yes No

How would you describe the frequency of your symptoms?  Constant  Comes & Goes

Please list any other health concerns: \_\_\_\_\_

List the names of your doctors: \_\_\_\_\_

Do you smoke or use tobacco? Yes No If yes, what type, how much and how often? \_\_\_\_\_

If former smoker – date of cessation: \_\_\_\_\_

Do you drink alcohol? Never Rarely Occasionally Moderately Daily

Surgical history with dates: \_\_\_\_\_

Current illnesses / Health Issues (thyroid disease / heart disease / diabetes, / etc.) \_\_\_\_\_

Current medications and doses: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Have you been in an auto accident?  Yes  No If yes, in what year(s)? \_\_\_\_\_

Please list all other major past injuries (work injuries, falls, etc.), including the years. \_\_\_\_\_

What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_ Do you exercise routinely? Yes No

**FAMILY HEALTH HISTORY:** Please list all health conditions for your close family relatives (parents, siblings, grandparents). Many conditions are hereditary and this information is helpful in providing your care.

NAME	RELATION	HEALTH PROBLEMS	DECEASED?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**WOMEN ONLY: X-RAY CONSENT:** X-rays can be harmful to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to x-rays.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Please list the *first day of your most recent menstrual cycle:* \_\_\_\_\_

## Informed Consent for Treatment

### **Informed Consent / Consent for Care**

\_\_\_\_ I have been informed of the nature, purpose and scope of care to be provided by the doctors of Ontario Chiropractic, the possible limitations and consequences of that care, and the possibility that the care given by Ontario Chiropractic may not help or resolve my complaint, dysfunction or condition.

\_\_\_\_ I consent to care and recommendations made by the doctors of Ontario Chiropractic for myself (or my children, if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies (including massage, traction, hot or cold application) and rehabilitation.

\_\_\_\_ I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups.

\_\_\_\_ I understand that my treatment will comply with the standard of care defined by the laws in the state of Oregon.

\_\_\_\_ I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures, may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors.

I hereby accept the risks associated with any care by the doctors and staff of Ontario Chiropractic and release them of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff of Ontario Chiropractic permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Ontario Chiropractic.

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*Patient Name (please print)*

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*Patient Signature*

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*Date*

## Acceptance of Terms

### Statement of Acknowledgement of Financial Responsibility

\_\_\_\_\_ I understand that I am responsible for any charges incurred at this office, including co-pays, deductibles, and any services denied or not covered by my insurance company. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are strictly your responsibility. **I agree to be personally and fully responsible for payment of any denied or non-covered charges.**

\_\_\_\_\_ I understand that it is my responsibility to know the coverage for chiropractic care provided by my specific insurance company and plan, including deductibles, co-pays and non-covered services. (Although we are contracted with several insurance companies, it is your responsibility to know the benefits for your specific health plan, including deductibles, co-pays, etc. We will assist you in any way we can to help make this process as smooth as possible, but we do not guarantee insurance coverage.)

\_\_\_\_\_ I authorize the release of my records as necessary for billing purposes.

\_\_\_\_\_ At the time of service, you will be responsible for any fees, co-pays, co-insurance, deductibles and non-authorized or non-covered services. For your convenience, we accept cash, checks, Visa and MasterCard. Special payment arrangements may be made by contacting the office manager. You will receive a monthly statement if there is a balance owed. A 1.5% monthly interest may be applied to all past due accounts that become uncollectible. In the event of nonpayment to Ontario Chiropractic, the balance may become due and payable in full and may be referred to a collection agency or to an attorney for legal action. By signing, you agree to pay for any reasonable court costs, attorney's fees and other applicable costs of collection. Any claim filed for the purpose of collection will be filed under the jurisdiction governing claims for the address of Ontario Chiropractic indicated above.

### **Auto & Work Related Injuries:**

\_\_\_\_\_ Billing will be submitted to the appropriate insurance provider. In the event that my claim is rejected, I understand that I will be liable for all charges and expenses related to my care. (If your injury claim is rejected, Ontario Chiropractic agrees to bill your personal health insurance provider for compensation.)

### **Use and Disclosure of Health Care Information:**

\_\_\_\_\_ Ontario Chiropractic may collaborate with other providers to coordinate, manage and provide optimal care. This consent may include the release of written records, electronic health records (EHR), x-rays and x-ray reports, diagnoses (including sensitive information, such as HIV or sexually transmitted diseases, substance abuse, mental health information, etc.). I agree that Ontario Chiropractic may use and disclose my health information for a range of purposes such as: treatment, eligibility verification, collection, communications with payors (including your insurance, Workers' Compensation programs, etc.), quality of care assessment (such as internal reviews or insurance reviews, audits, etc.), and public health and health oversight services (when reporting is required by state or federal law).

\_\_\_\_\_ I consent to Ontario Chiropractic's request for health information from other providers of care, whether written, verbal or electronic, for the uses described above.

\_\_\_\_\_ I understand that a copy of the written Privacy Policy for Ontario Chiropractic is available upon request.

Signing below indicates that you have read and understand your obligations for payment for all services provided by the doctors and staff of Ontario Chiropractic.

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*Patient Name* (please print)

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*Patient Signature*

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*Date*

## Insurance Information

**Personal Insurance:** *Please note that we do not provide billing to secondary insurance companies. If you have a secondary insurance provider, please ask the receptionist how to collect reimbursement for your care.*

Patient's name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ins. ID / Policy #: \_\_\_\_\_

**Workers Compensation Insurance:** Date of Accident / Injury: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Comp Carrier: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ins. ID / Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

**Auto Injury Insurance:**  
***Patient's Insurance Information***

Patient's name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ins. ID / Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Location of Accident (State): \_\_\_\_\_

***Other Party's Insurance Information (if applicable)***

Policy Holder: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ins. ID / Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

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I authorize the doctor to furnish my attorney and/or insurance company with any necessary documentation related to my treatments at Ontario Chiropractic relating to the injury listed above.

I hereby give a lien to the my treating doctor at Ontario Chiropractic on any settlement, judgment, or verdict as a result of my injury and authorize and direct you, my attorney / insurance provider, to pay directly to my doctor any sums due him/her for services rendered me, and to withhold such sums from any settlement, judgment, or verdict as necessary to protect my doctor adequately.

\_\_\_\_\_  
Patient Signature (or guardian)

\_\_\_\_\_  
Date