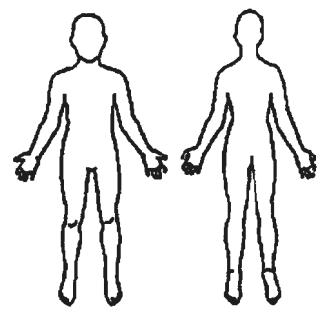


Patient Entrance History

<p style="text-align: center;">1. PATIENT INFORMATION</p> <p>Date _____</p> <p>First Name: _____ Middle _____</p> <p>Last Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Sex: M F Age: _____ Birthdate: _____ Single Married Divorced Widowed Separated</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Employer address _____</p> <p>Spouse's Name: _____</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Names and ages of children: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">2. INSURANCE</p> <p>Who is responsible for account? _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Is patient covered by additional insurance? Yes No</p> <p>Subscriber's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to patient _____</p> <p style="text-align: center;">ASSIGNMENT AND RELEASE</p> <p>I, the undersigned certify that I (or my dependent) have insurance coverage with above named Insurance company and assign directly to Dr. Huppert 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 understand that I am financially responsible for all charges if I do not have insurance. I hereby 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.</p> <p>_____</p> <p>Responsible Party Signature _____</p> <p>Relationship _____ Date _____</p>
<p style="text-align: center;">3. PHONE NUMBERS</p> <p>Home _____ Cell _____</p> <p>Work _____ Ext. _____</p> <p>May we contact you at work? Y / N</p> <p>Would you like text appointment reminders? Y / N</p> <p>Cell Phone Provider _____</p> <p>E-mail Address _____</p> <p style="text-align: center;">IN CASE OF EMERGENCY, CONTACT</p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Work Phone _____</p>	<p style="text-align: center;">4. ACCIDENT INFORMATION</p> <p>Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p>Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> _____</p> <p>To whom have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> _____</p> <p>Attorney Name (if applicable) _____</p>
<p style="text-align: center;">5. PATIENT CONDITION</p> <p>Primary Concern _____</p> <p>When did your symptoms appear? _____</p> <p>Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Mark an X on the picture where you continue to have pain, numbness, or tingling.</p> <p>Rate the severity of your pain on a scale of 1 (least pain) or 10 (severe pain) _____</p> <p>Type of pain (circle all that apply) Sore Dull Aching Sharp Stabbing Burning Tingling Numbness Other _____</p> <p>How often do you have this pain? _____</p> <p>Does it interfere with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation</p> <p>Activities or movements that are painful to perform: <input type="checkbox"/> Bending <input type="checkbox"/> Laying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing</p> <p>Activities or movements that make it feel better: <input type="checkbox"/> Lying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Movement</p> <p>What treatment have you already received for your condition? <input type="checkbox"/> Medications <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Chiropractic <input type="checkbox"/> None <input type="checkbox"/> Other _____</p>	



Last Name: _____ First Name _____ Date _____

6. HEALTH HISTORY

Please check any of the following symptoms you have experienced since your accident.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Stressed Shoulders |
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Leg and Hip Problems | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Energy/Fatigue | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Other _____ |

Have you ever been diagnosed or told you have one of the following diseases, disorders, or medical conditions?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Bones/Joint | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Loss of Bowel/Bladder Control | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Sinus Problems | |

HABITS

- | | |
|--|-------------------|
| <input type="checkbox"/> Smoking | Packs/Day _____ |
| <input type="checkbox"/> Coffee/Caffeine | Cups/Day _____ |
| <input type="checkbox"/> Alcohol | Drinks/Week _____ |
| <input type="checkbox"/> High Stress Level | Reason _____ |

MEDICAL HISTORY

- Date of last MRI, CT-Scan, Bone Scan or other _____
- Name of Doctors who have treated you for your condition _____
- Name of your Primary Physician _____

EXERCISE

- None Moderate Daily Heavy

WORK ACTIVITY

- Sitting Standing Light Labor Heavy Labor Computer Driving

7. MEDICATIONS, VITAMINS, and SUPPLEMENTS (name and purpose)

Is there anything else which may help us to better understand your history which has not been discussed on this survey?

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

INJURY HISTORY

Name: _____ #: _____

Office: _____ Date: ___/___/___

AUTOMOBILE COLLISION WORK ACCIDENT HOME ACCIDENT OTHER

1. Date of Accident: ___/___/___ Time of Accident: ___:___ AM PM

2. State how accident happened in your own words:

3: If work related:

a. List any equipment, machinery and/or object related to the accident:

b. What is your job title or activity: _____

c. Has accident been reported to supervisor or employer? Yes No

d. Name of person reported to: _____ Title: _____

4. If motor vehicle related:

a. Were you: Driver Passenger Pedestrian *If passenger: Front Seat Back Seat

b. What kind of vehicle were you in?: Car Truck Motorcycle Other

Size and type of vehicle: _____

c. If passenger, were you sitting in: Front Right Rear Left Rear

d. Did your vehicle strike: Other vehicle(s) Sign Tree Bridge Hedge Embankment

Deer Other: _____

e. How fast were you going?: _____ mph

f. Did your vehicle go off the road?: Yes No

If so: Into a ditch An Embankment How deep?: _____

g. Was your vehicle hit by other vehicle(s)? Yes No

If yes, what kind of vehicle hit yours: Car Truck Motorcycle Other _____

Size and type of vehicle: _____

h. Where was your vehicle hit?: Front Back Left Side Right Side

i. What damage was done to your vehicle? Inside:

Outside: _____

j. Do you have pictures of the involved automobile?: Yes No

k. Were you wearing a seatbelt?: Yes No Shoulder harness on?: Yes No

l. Did you hit any part of your body during the collision, for example, head on dash, chest on steering

wheel?: Yes No

If yes, which part and how?: _____

m. Did airbags deploy? Yes No If yes: Front Side

COMPLETE FOR ALL ACCIDENTS

6. Immediately following the accident, how did you feel?:

Were you unconscious?: Yes No

7. Did you go to the hospital?: Yes No

If so, when did you go?: At time of accident Next day Other: _____

How did you get to the hospital?: Ambulance Private Transportation

Did the ambulance attendants place you in a neck collar?: Yes No

In Splints?: Yes No In a Brace?: Yes No

8. Name of Hospital: _____

9. Name of Doctor: _____

10. Were you x-rayed at the hospital?: Yes No

If so, what was your diagnosis?: _____

11. Were you admitted to the hospital?: Yes No

What treatment was rendered?: _____

How long was your stay?: _____

What recommendations were made?: _____

12. Have you seen any other doctors as a result of this accident?: Yes No

If yes, who?: _____

13. Have you lost any time from work because of this accident? Yes No

If yes, give dates of disability – Totally disabled from ___/___/___ thru ___/___/___

Partially disabled from ___/___/___ thru ___/___/___

14. Have you returned to work since that accident?: Yes No

15. Please complete the following:

Date	Employer	Occupation	Light duty/ Reg. duty	Full-time Part-time

16. Since this accident occurred, are your symptoms: Improving Getting worse Same

17. Do you notice any activity restrictions as a result of this injury?: Yes No

If yes, please describe: _____

18. Have you ever been injured in a similar manner?: Yes No

If yes, how and when? _____

19. Have you had to have any outside help?: Yes No

Car Accident Only:

30. Does it bother you to ride in a car now? Yes No

If so, Which one bothers you more?: As a Driver As a Passenger

NOTES

Patient, Agent, or Representative

Witness

Relationship

___/___/___
Date

Five Points Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up-coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the office manager at (706) 546-7700. If she/he is unavailable, you may make an appointment with our receptionist to see her/him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

Five Points Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Five Points Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

DOB

HR#

Patient signature

Date

Witness

Date