

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

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

INSURANCE

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

ACCIDENT INFORMATION

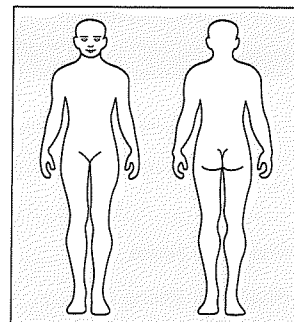
Is condition due to an accident? ☐ Yes ☐ No

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) _____



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:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ 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 (____) _____

Informed Consent

Patient Name: _____ **Date:** _____

Please read this entire document prior to 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 used by Doctor of Chiropractic is spinal manipulative therapy. Dr. Estner and/or associates may use his/her hands or a mechanical instrument in such a way as to realign the joints. This may cause an audible “pop” similar to the noise when you crack your knuckles.

The material risks inherent in a chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to serious complications including stroke. Other types of complications include but are not limited to the following: fractures, disk injuries, dislocations, muscle strain, cervical myelopathy (nerve injury) and burns. Some patients will feel some stiffness and soreness following the first few days of treatment, this is normal.

The doctor will make every reasonable effort during examination to screen for contraindications to receiving care; however, if you have a condition that would otherwise not come to the doctor’s attention, it is your responsibility to inform the doctor.

I have read the above explanation of the chiropractic adjustment and related risks. I have discussed this document with Dr. Estner and/or associates and have had my questions answered to my satisfaction. By signing below, I have weighed the risks involving and undergoing treatment and have decided that it is my best interest to undergo the recommended treatment.

Signature: _____

MAIN OFFICE - CRANSTON

875 Pontiac Avenue, RI 02910 • 401.275.2225.ph | 401.275.0620.fx

NORTH SMITHFIELD/WOONSOCKET

894 Great Road, Suite 105, RI 02896 • 401.829.2225.ph | 401.766.0602.fx

PAWTUCKET

7 George Street • 401.724.7246.ph | 401.724.7242.fx

PROVIDENCE

500 Broad Street • 401.751.2225.ph | 401.751.2227.fx

PRIVACY AND COMMUNICATION

PRIVACY POLICY

All patient information is confidential. Every attempt will be made to respect confidentiality when communicating. Privacy policy is posted in each office. Patient information will be released with signed consent. Family members/friends are not permitted to obtain any personal information without signed consent. Employees of Estner Injury Centers have reviewed this privacy policy.

PERMISSION OF CORRESPONDENCE:

- I grant permission to receive appointment text reminders
- I grant permission to leave a voicemail on my phone
- I grant permission to be contacted regarding test results, confirmation of appointments and insurance
- I grant permission to communicate with the office via text and phone

Signature of Patient

Date:

(Minors) Parent/Legally Authorized Representative

Relationship to Patient

Date:

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