Gillette Chiropractic Center
1001 S 4 J Road
Gillette, WY 82716
(307)686-2327
Todd A. Hildebrand D.C.

Name_____ Chart Number_____

Full Name: _____I prefer to be called: _____Male___Female___
First Last MI

Birthdate: _____/_____/_____ Age: _____ Social Security #_____ Single/Married/Divorced/Widowed/Separated

Mailing Address: _____
Street City State/Zip

Cell Phone: _____ Work Phone: _____ Ext: _____

Other family members treated by us: _____

Your employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

SPOUSE, GUARDIAN, OR PRIMARY INSURED INFORMATION

Name: _____ Relation: _____

Birthdate: ____/____/____ Social Security #: _____ Cell Phone: _____

Mailing Address:

_____
Street City State/Zip

Employer: _____ Work Phone: _____ Ext: _____

This section is required if you marked "married" above or are not the primary insurance holder.

PAYMENT POLICIES

Please initial payment method.

Checks and Credit: We accept cash, check, MasterCard, Visa, and Discover. If necessary, payment arrangements can be made available. _____

Insurance: We will be happy to file with most insurance companies, including those for which we are not providers. Insurance payment is expected in a reasonable amount of time, otherwise you will be billed personally and expected to pay the remaining amount. ____

Medicare: Gillette Chiropractic Center is not currently a participating provider. We will file your claims to Medicare but ask for payment at the time of service. Reimbursements will be paid directly to the patient from Medicare. The amount reimbursed will be based on what treatment Medicare determines to be medically necessary. ____

Workers Compensation: We must verify with your employer that you sustained an injury while on the job. All state required paperwork must be completed at the time of your first visit. I understand that the determination of payment for an on-the-job accident is solely determined by Wyoming Workers' Compensation. I further understand that all the charges incurred by me are my responsibility in the event that my case is denied. ____

Auto Accident/Personal Injury: Your MedPay (automobile insurance information) is required for billing purposes. I understand that my insurance will be billed, even in the event of an accident, in which I am not at fault. ____

Minors: Parents, if you are bringing in a minor for treatment, you are responsible for the charges incurred. In the event of a split household, we do not bill a third party (i.e., each parent pays 50%). It is the policy of Gillette Chiropractic Center that the parent who brings the minor in for treatment is financially responsible. I understand the above policy and agree to be responsible for the charges incurred. ____

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

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Doctors Name: _____ City: _____

Your current physical health is: Good ___ Fair ___ Poor ___

Are you currently under the care of a physician? Yes___ No___
If "yes" please explain why: _____

Name of Doctor? _____

Do you smoke or use tobacco in any form? Yes___No___ Chew___ Smoke ___Vape___

Are you right or left-handed? Right___Left___

Have you ever been to a Chiropractor before? Yes___No___

Name of Chiropractor? _____

If "yes" when and for which body part? _____

Were X-rays taken? Yes___No___

Have you ever been involved in a bicycle, motorcycle, bus, train, or other vehicular accident? Yes ___ No ___

If "yes" please list the approximate date:_____

Were you knocked unconscious? Yes___ No ___ How many times _____

Have you ever broken any bones? Yes___ No ___

If "yes" please list:_____

Have you had any impact, falls, or jolts that you feel specifically may have injured your spine? Yes___ No ___

If "yes" please explain: _____

Do you read for a prolonged period of time? Yes___ No___

Do you have a particular position for watching TV? Yes___ No ___

Are you wearing: Heel Lifts, Sole Lifts, Inner Soles, Arch Supports? _____

***Please list all surgeries with approximate dates:**

_____

_____

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SYMPTOM/PAIN INFORMATION

***Please describe the pain for which you came to our office: _____**

What caused your symptom(s) to occur: _____

What aggravates your symptom(s): _____

Please describe the character of your symptoms (burning, stinging, tingling, aching, tired, numb, shooting, etc.) _____
_____

How many times have you had a problem similar to or the same as this in the past? _____

Did it begin: Gradually___Suddenly___ Since it began, has it: Improved___Worsened___ Stayed the same___

Are your symptoms constant? Yes___ No___

Are there any times or positions when you do not experience pain or discomfort? Yes___ No___

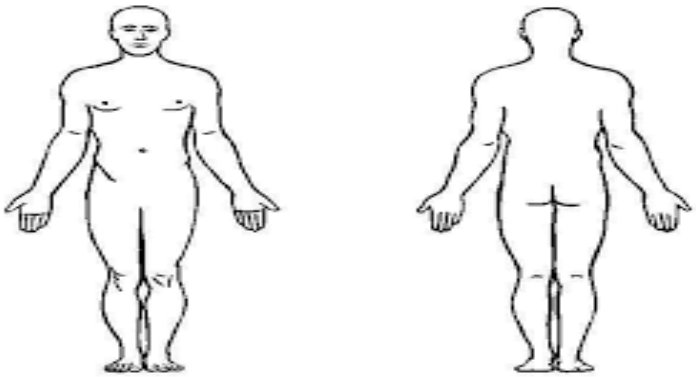
If "yes" please explain: _____

Are you restricted/limited in any work, home, or recreational activities because of your discomfort? Yes___ No___

If "yes" please explain: _____

What type of physical activity does your job involve (prolonged sitting, standing, bending, etc.) _____

Please mark the areas of injury or discomfort below, include the degree of pain using 0=no pain and 10=severe pain:



0-no pain 10-severe pain

***How long have you had this episode of your symptoms? _____**

Are your symptoms the result of an auto accident, work or personal injury? Yes___ No___

Have you done anything to try and help relieve your complaint such as: rest, heat, ice, aspirin: Yes___ No___

If "yes" please list:_____

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Are you taking any of the following?

Please list any prescription/ over the counter medications not listed:

_____
_____
_____
_____

Acetaminophen (Tylenol)	Yes__ No__
Ibuprofen (Advil)	Yes__ No__
Antibiotics	Yes__ No__
Antihistamines	Yes__ No__
Aspirin	Yes__ No__
Thyroid Medication	Yes__ No__
Blood Thinners	Yes__ No__
Blood Pressure Medication	Yes__ No__
Cold Remedies	Yes__ No__
Digitalis/Heart Medication	Yes__ No__
Tranquilizers	Yes__ No__
Insulin/Diabetes Drugs	Yes__ No__
Nitroglycerin	Yes__ No__
Recreational Drugs	Yes__ No__
Steroids/ Cortisone	Yes__ No__

For Women

Are you on birth control? Yes__ No__
Type of birth control: Pill __ Patch __ Ring__ Other __
Are you pregnant? Yes __ Week # __ No __ Unsure __
Due Date: _____
Current OB:_____
Any problems with pregnancy? _____
Age your period stopped and why _____
_____

DO YOU HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies
Y N Anemia
Y N Arthritis
Y N Artificial Bones/ Joints Specify: _____
Y N Asthma
Y N Blood Transfusions
Y N Cancer Year:____ Type:_____
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Depression
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fatigue
Y N Fever Blisters
Y N Glaucoma
Y N Gout
Y N Hay Fever
Y N Headaches
Y N Heart Disease/ Problems
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason
Y N Kidney stones
Y N Leukemia
Y N Liver Disease/ Problems
Y N Low Blood Pressure
Y N Lupus
Y N Migraines
Y N Mitral Valve Prolapse
Y N Obesity
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Rheumatism
Y N Scarlet Fever
Y N Sciatica
Y N Scoliosis
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke Year: _____
Y N Suicidal Problems
Y N Thyroid Problems
Y N Tonsilitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

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The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss this with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Hildebrand and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to treatment.

_____ _____ _____
Patient's Name Patient's Signature Date

Todd A. Hildebrand, D.C

_____ _____ _____
Doctor's Name Doctor's Signature Date

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

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INFORMED CONSENT DOCUMENT

To the patient: 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 I use as a Doctor of Chiropractic is a spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As part of the analysis, examination, and treatment, you are consenting but not limiting to the following procedures: (Please Initial)

___ Spinal Manipulative Therapy, Palpation, Hot Pack Therapy, Range of Motion Testing, Orthopedic Testing, Basic Neurological Testing, Mechanical Traction, Postural Analysis, Electric Muscle Stimulation, Muscle Strength Testing, Radiographic Studies (X-Rays)

POSSIBLE RISKS OF TREATMENT

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check for during the taking of your history and during examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

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Health Insurance Portability and Accountability Act (HIPPA) Consent

This HIPPA consent is not related to you having or not having health insurance. This simply verifies that we will not share your information with anyone without your written consent.

ACKNOWLEGMENT

I acknowledge Gillette Chiropractic Center maintains a current copy of the Practice Privacy Notice and I may review it at any time.

I affirm that information I have provided is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.
In the event my account requires 3 consecutive billing statements or more, I understand that I will be assessed a $5.00 billing statement fee per monthly statement starting with the third statement.
I hereby authorize Gillette Chiropractic Center to furnish all information required by my insurance company concerning my injury or illness.
I authorize the release of information to family physicians and employer. (Only in the event of a work related injury.)
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostics and therapeutic procedures for treatment purposes.
In the event this account is referred to a professional collection agency, I agree to pay all costs and fees associated with collecting this account, which may be 45% of the principal balance in addition to the principal balance owed to Gillette Chiropractic Center.
I authorize my insurance benefits to be paid directly to: **Gillette Chiropractic Center**
1001 S 4-J Road
Gillette, WY 82716

Signature: _____ Date: _____/_____/_____

This section only required if the paperwork is filled out by someone other than the patient

Paperwork filled out by: _____ _____
Name of Individual (Printed) Signature of Individual

Spouse/Child/Guardian/Other Please Specify: _____