PATIENT INFO

Name:
(LAST) (MI) (FIRST)

Address:
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec # - -

Driver's License #: State:

Marital Status: S M D W Minor Other: Spouse's Name:

Your Employer: Your Occupation:

Employer Address:
(STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Medicare

Insurance Name:

Member #: Group #:

Insured's Name (If Different From Patient): Relationship to Patient:

Insured's DOB: / / Insured's Soc. Sec #: - -

Insured's Employer:

Person responsible for account:

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.

Patient/Guardian Signature: **Date:**

______________________________ ______________

Health History

Patient Name: ____**DOB:** ____________**Date:** ________________

Chief Complaint:____

History of Present Illness:

Specific Location: ________________________________
(Where is the pain/problem?)

Quality: Sharp Dull General Electric-like
Shooting Stiff Numb Tingling Achy
(Please circle all that apply)

Severity: 1 2 3 4 5 6 7 8 9 10
(How severe is the pain/problem on a scale of 1-10, with 10 being the most severe)

Duration: ______________________________________
(How long have you had this problem?)

This problem is: Getting Worse Staying the Same Getting Better

Date of Onset:__________________________________

What aggravates it?: _____________________________

____
(What makes the pain/problem worse?)

How did this problem begin?:____________________

____
(Slip, fall, auto accident, sports injury, unknown)

What helps?: ____
(What makes it better? Ice, heat, massage therapy, medication, stretching, etc.)

How often do you feel this problem/pain?:
_______Constant (75-100% of the time)
_______Frequent (50-75% of the time)
_______Occasional (25-50% of the time)
_______Intermittent (1-25% of the time)

Past Medical History (Have you ever had the following? Please circle **ALL** that apply):

Measels	Epilepsy	Hemorrhoids	Any other disease(s)?
Mumps	Migraines	Mitral Valve Prolepses	______________________
Chicken Pox	Headaches	Asthma Stroke	______________________
Whooping Cough	Tuberculosis	AIDS/HIV	______________________
Scarlet Fever	Diabetes	Infectious Mono	______________________
Diptheria	Hives of Eczema	Bronchitis	______________________
Small Pox	Polio	Hepatitis	______________________
Pneumonia	Glaucoma	Ulcer(s)	
Rheumatic Fever	Hernia	Kidney Disease	
Arthritis	Blood or Plasma Transfusion	Thyroid Disease	
Venereal Disease	Back Trouble	Bleeding Tendency	
Anemia	High Blood Pressure	Cancer - Type:	
Bladder Infection	Low Blood Pressure	______________________	

Previous Hospitalizations/Surgeries/Serious Illnesses:

Type	Date of Occurrence	Hospital, City/State
______________________	______________	______________________
______________________	______________	______________________
______________________	______________	______________________

Health History

Medication (Include non-prescription):

Name	Dosage/Frequency
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Have you ever taken Fen-Phen/Redux? YES NO

Are you currently taking any medications (prescriptions or over the counter) for acid indigestion? YES NO
If yes, what type?: ____________________

Allergies: (Please list any allergies you may have) ____________________

____

____

<u>Patient Social History:</u>

Marital Status: Single______ Married_____ Separated_____ Divorced_____ Widowed_____ Minor_____

Use of Alcohol: Never______ Rarely______ Moderate_____ Daily______

Use of Tobacco: Never______ Rarely______ Moderate_____ Daily______

Use of Drugs: Never______ Rarely______ Moderate_____ Daily______ Type:____________________

<u>Family Medical History:</u>

Age	Disease(s)	If Deceased, Cause of Death
Father: ____________	____________________	____________________
Mother:____________	____________________	____________________
Sibling(s):__________	____________________	____________________
________________	____________________	____________________
________________	____________________	____________________
Spouse:____________	____________________	____________________
Children:___________	____________________	____________________
________________	____________________	____________________
________________	____________________	____________________

Health History

Please indicate which of the below you have experienced in the last 1-2 months
1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Frequently; 5 = Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore Throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache/Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migranes	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/Needles in Hands/ Feet	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t Shoulder Blades	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise (Onset of Illness)	1 2 3 4 5
Weakness, Tiredness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling Foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any charges in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________
Signature of the Patient, Parent or Guardian Date

____ ____________________
Signature of Doctor Date

Insurance Verification Disclosure/Agreement

As a courtesy, Trinity Chiropractic & Trinity Integrated Medical will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed): ______________________________________ Date: _______________

Patient Signature: ____

Parent/Guardian Signature: ____

Office Manager: ____Date: _______________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **TRINITY CHIROPRACTIC CENTER, TRINITY INTEGRATED MEDICAL, TIMOTHY J. USELTON D.C., MONTE NOCUS D.C., RACHEL L. SELF F.N.P.-C, OR NEERAJ B. SHAH M.D.** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health services or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependant) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my /our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitles, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to:

☐ Trinity Integrated Medical, 3008 E Hebron Pkwy, Bldg 500, Carrollton, TX 75010

☐ Trinity Chiropractic, 3008 E Hebron Pkwy, Bldg 500, Carrollton, TX, 75010

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _______ day of _____________, 2018
Day Month

X____________________________________
(Patient, Parent/Guardian, Representative Signature)

X____
(Signature of Witness)

____
(Please Print Patient Name)

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information
Information to Be Used or Disclosed

The information covered by this authorization includes: All Patient Medical Records

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

TRINITY CHIROPRACTIC and/or TRINITY INTEGRATED

Expiration Date of Authorization

This authorization is effective through: 12/2018 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize the above mentioned entities to use my protected information for the listed reasons.

Patient Name (Printed): ____ Date: _______________

Patient Signature: ____

Parent/Guardian Signature: ____

Office Manager: ____ Date: _______________

TRINITY INTEGRATED MEDICAL
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (print) ____

Patient/Guardian Signature____ Date ________________

Witness Signature ____ Date________________