New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date if Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

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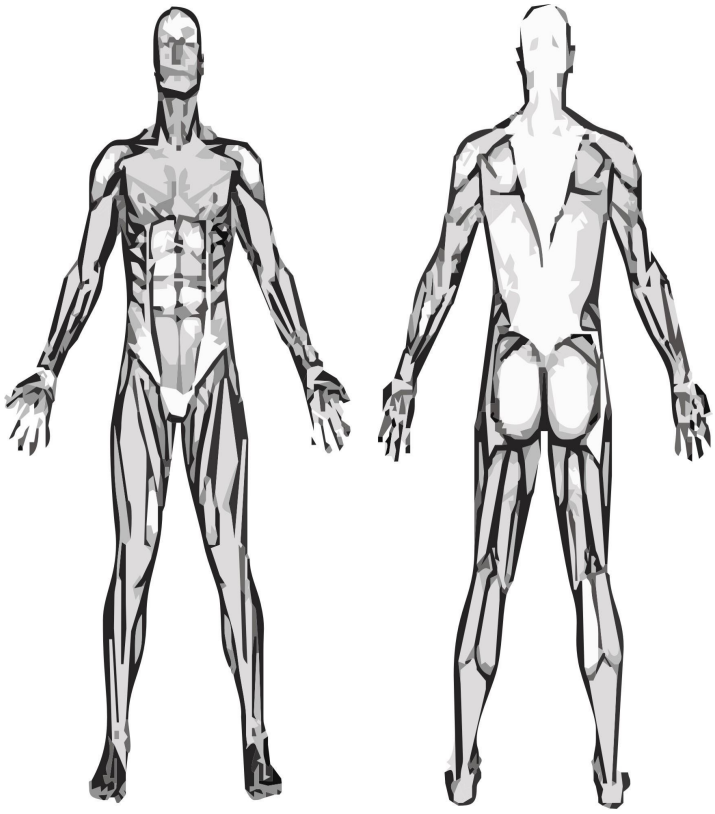
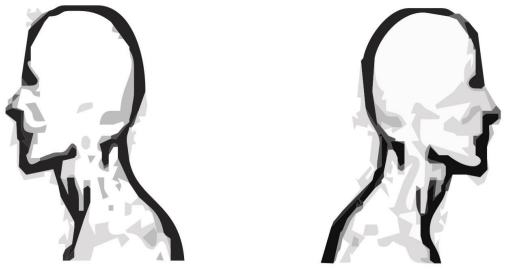
Have you ever suffered from:

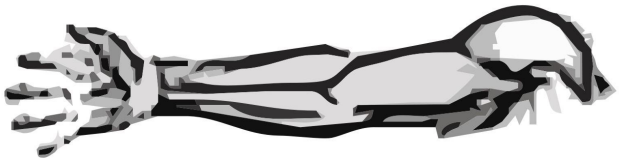
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







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STANDRIDGE CHIROPRACTIC

(918)665-7077P* (918)665-7099F

10390 E 21ST TULSA OK 74129

GENERAL FUNCTIONS

We are interested in knowing whether you are having any difficulty at all with the activities listed below.Target the problem for which you are currently seeking attention. Please provide an answer for each activity.

TODAY, do you or would you have any difficulty at all with:

	Activities	Unable to Perform	Much Difficulty	Some Difficulty	Little Difficulty	No Difficulty
1	Usual work, housework, or school	4	3	2	1	0
2	Usual hobbies, recreational or sports	4	3	2	1	0
3	Getting in or out of the bath tub	4	3	2	1	0
4	Walking between rooms	4	3	2	1	0
5	Putting on shoes or socks	4	3	2	1	0
6	Squatting	4	3	2	1	0
7	Lifting an object	4	3	2	1	0
8	Light activites around the home	4	3	2	1	0
9	Heavy activities around the home	4	3	2	1	0
10	Getting in or out of a car	4	3	2	1	0
11	Walking 2 blocks	4	3	2	1	0
12	Walking a mile	4	3	2	1	0
13	Up or down 10 stairs	4	3	2	1	0
14	Standing for 1 hour	4	3	2	1	0
15	Running on even ground	4	3	2	1	0
16	Running on uneven ground	4	3	2	1	0
17	Making sharp turns while running fast	4	3	2	1	0
18	Hopping	4	3	2	1	0
19	Rolling over in bed	4	3	2	1	0
20	Sitting for 1 hour	4	3	2	1	0
	COLUMN TOTALS:					

Welcome to our office. Please take a moment to review our policy. This information will help you understand some of the rights and benefits you have available. It will also outline how personal injury claims are handled in our office.

GENERAL INFORMATION:

1. We will routinely file claims and liens with the insurance company involved in your case. This may include your auto or major medical health insurance carrier.

2. You may wish us to bill your own auto insurance carrier as well as the responsible party's insurance carrier. By having your policy cover your medical bills, you will receive a larger portion of your final settlement. You are paying premiums for this coverage. No, your rates should not go up for collecting the medical pay portion of your policy. But, we recommend you contact your agency to verify this information.

3. If you do not have medical pay coverage, the liability coverage of the person's at fault insurance should pay for your medical treatment.

4. If your group or personal health insurance allows for coverage due to an automobile injury, at your request, we will also submit those claims on your behalf.

5. You will remain responsible for any unpaid balance. Should payment be received from more than one source and your account has a credit, that amount will be refunded to you.

6. If you wish an attorney to handle your case, thus insuring that all your rights will be upheld, we strongly recommend that you use an attorney who regularly works with the chiropractic profession.

MEDICAL AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Dr. Travis Standridge to release pertinent medical information concerning my condition to my attorney or any third party payer involved in my case.

Patient Signature: X_____ **Date:** _____

AUTHORIZATION TO PAY DOCTOR: I hereby authorize and direct my attorney or insurance company representative to pay benefits resulting from any financial settlement directly to Dr. Standridge for any medical sums owed on my account as a result of my loss.

Patient Signature _____ **Date** _____

PERFERRED METHOD OF PAYMENT (check all that apply)

☐ **Cash**. Payment at the time of each visit. We will be happy to supply any itemized statements along with your diagnosis.

☐ **Med Pay Coverage.** Please present your insurance verification to the front desk.

☐ **Liability Coverage.** If approved, we may await payment until your case is settled. Your balance must be paid in full immediately upon settlement. In the event your case settlement exceeds six (6) months beyond your release date, the health care professional reserves the right to demand full payment from the patient.

☐ **Major Medical Coverage.** Please present your insurance verification card to the front desk.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr Standridge's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. **However, I clearly understand and agree that all services rendered 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ **Date** _____ **Social Security #** _____ - _____ - _____

Witness _____ Date _____Title _____

STANDRIDGE CHIROPRACTIC

10390 E 21 ST
TULSA OK 74129
918-665-7077
918-665-7099 FAX

PLEASE READ AND SIGN THE AGREEMENT LISTED BELOW:

I hereby give Dr. Travis Standridge and/or his office staff permission to communicate with me regarding future appointments via phone, e-mail, or mail service. As well as recognizing my name for future referrals on the referral board and thank yous for said referral.

SIGNATURE	
DATE	

PRIVACY PRACTICES

We are required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
If you would or would not like a copy of our NOTICE OF PRIVACY PRACTICES, please indicate below. You may at a later time request a copy of NOTICE OF PRIVACY PRACTICES by speaking with our HIPPA Compliance Officer.

_____ I do not wish to receive a copy of our NOTICE OF PRIVACY PRACTICES at this time.
_____ I do wish to receive a copy of our NOTICE OF PRIVACY PRACTICES at this time.

_____ _____
SIGNATURE DATE

_____
PRINT NAME

MISSED APPOINTMENT and LATE FEE NOTICE

Out of courtesy of our doctor and staff's time, there will be $30.00 fee for a missed appointment. In order to avoid this fee, please give us 24 hours notice if you will not be able to make your set appointment.
I understand that all payment is due at the time of service. If under any circumstances I have a balance on my account, I will be sent a statement. If not paid in 30 days after last visit I will be charged a $30.00 late fee each month it is not paid.
These fees will and can only be waived by order of Dr Standridge in certain situations as deemed necessary by him.
Your understanding of this notice is noted by the signing of your name below.

_____
PATIENT SIGNATURE OF APPROVAL

Dr Travis D Standridge
STANDRIDGE CHIROPRACTIC