STAMFORD
PHYSICAL MEDICINE

NEW PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ _____ _____
Last First MI

Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Sec #: _____ **Gender:** ☐ Male | ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____

Race/Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American

☐ Other: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Phone Number: _____ Alternate Phone Number: _____

ACCIDENT INFORMATION

Is this visit due to an accident? ☐ Yes ☐ No | **If yes, what type?** ☐ Auto ☐ Work ☐ Other: _____

A brief description of the accident: _____

Has it been reported? ☐ Yes ☐ No | If yes, to whom? _____

INSURANCE INFORMATION

Policy Holder Name: _____ Date of Birth: _____

Relationship to patient (if other than self): _____ Phone: _____

Do you have health insurance ☐ Yes ☐ No | Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No | Name of Carrier: _____

Are you covered by Medicare? ☐ Yes ☐ No | Medicare #: _____

SYMPTOM INFORMATION

Check off any of the following symptoms you have experienced in the past six months:

- ☐ Lower Back Pain
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Pain Between Shoulder Blades
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Elbow Pain
- ☐ Neck Pain
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Hip Pain
- ☐ Tension/Headaches
- ☐ Pain in the Legs
- ☐ Digestive Problems
- ☐ Fibromyalgia
- ☐ Pain in the Feet
- ☐ Carpal Tunnel
- ☐ Other (explain): _____

Which of the above is the worst?

How long have you had it?

Do you know when it started/what started it?

How often does it occur?

Describe what it feels like:

Does the pain move or stay in one place?

Is the pain worse at certain times of the day?

Do weather conditions affect your symptoms?

What activities/positions/treatments help this problem?

What activities/positions/treatments make it worse?

What activities would you like to do if this was not a problem?

Check off any of the following that apply to you:

This causes me to be: ☐ Moody ☐ Irritable ☐ Unable to sleep ☐ Restricted in Daily Activities

At work, this makes me have: ☐ Poor Decision Making ☐ Poor Attitude ☐ Lowered Productivity ☐ Exhaustion at the End of the Day ☐ Inability to Work Long Hours

At home, this makes me: ☐ Impatient with Spouse/Children ☐ Restricted in Household Duties ☐ Unable to Exercise or do Sports ☐ Unable to do Hobbies or Activities

Is there any further information about your symptoms that you think the doctor should be aware Of?

MEDICAL INFORMATION

Are you currently under drug and/or medical care: ☐ Yes ☐ No

Who is your primary care doctor? _____

Please list all medications/supplements/vitamins you take (please include dosage and frequency):

_____

_____

Please list any medical conditions you currently have or have had:

_____

_____

Do you have any allergies? _____

(For women) Date of last menstrual period: _____ **Any possibility of pregnancy?** ☐ Yes ☐ No

List any surgeries and/or hospitalizations you have had (please include type and date):

Do you smoke? ☐ Yes ☐ No (If yes) How many cigarettes/day?

Do you consume alcohol? ☐ Yes ☐ No (If yes) How many drinks/week?

Do you consume caffeine? ☐ Yes ☐ No (If yes) How many cups/day?

Exercise frequency: ☐ Never ☐ Daily ☐ Weekly ☐ Other:

Exercise type: ☐ Walk ☐ Run ☐ Swim ☐ Other:

Is there any family history of any of the following conditions?

*Please indicate parent(s), grandparent(s), child(ren) & sibling(s)

☐ Heart Disease: ☐ Diabetes: ☐ Cancer: ☐ Arthritis: ☐ Other:

OTHER INFORMATION

How did you hear about our practice?

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Private Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

Patients written acknowledgement of doctor's notice of privacy practices

I _____ , acknowledge that I have read and was given a copy of Inglis Chiropractic Center and/or Stamford Physical Medicine Notice of Privacy Practices. I fully understand it and have had all my questions answered to my satisfaction.

Patient Signature: _____ Date: _____

Parent/Guardian Signature Authorizing Care for Minor: _____

Patient Compliance

I understand and I agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Inglis Chiropractic Center and/or Stamford Physical Medicine will prepare any necessary report and form to assist me in making collections from the insurance company and that any amount anticipated to be paid directly to Inglis Chiropractic Center and/or Stamford Physical Medicine, power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered 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 will be immediately due and payable. In addition, a 1.5% monthly interest charge will be applied to all outstanding balances over 90 days.

Patient Signature: _____ Date: _____

Parent/Guardian Signature Authorizing Care for Minor: _____