Premier CHIROPRACTIC & Wellness

Dr. E. Dean Dierksen, D.C.
324C Southwind Pl
Manhattan, KS 66503
(785) 320-5300

# PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards. PLEASE PRINT.

**Full Name** _____ **Home Phone** _____ **Cell Phone** _____

**Preferred Name/Nickname:** _____

**Address** _____ **City** _____ **State** _____ **ZIP** _____

**Age** _____ **Birthday** _____ **Gender:** M F **Marital Status:** S M W D Sep **No. Children**_____

**Email** _____ **SS#**_____ **Driver's License #**_____

**Your Employer** _____ **Your Occupation** _____ **Years on Job** _____

Employer Address _____ City _____ State ____ ZIP _____

Work Phone _____ Do ***you*** have health insurance at work? Yes No

Insurance Company _____ Plan/Group #_____ Cert #_____

**How did you hear about our office?** Google_____ Internet _____ Radio_____ Coupon _____

Event _____ Facebook _____ Referring Doctor _____ Friend _____Other_____

Name & Phone Number of Emergency Contact : _____

**Is your condition due to an accident? Yes No Date of your Accident:** _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. The payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

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**List any accidents, injuries, falls and dates.**

__Car: _____

__Sports: _____

__School: _____

__Other: _____

**List any broken bones, dislocations, or sprains:**

_____

_____

**Have you ever had x-rays, MRI, or CAT Scan of your body? ___ Yes ___ No When? _____**

**Who is your:**

Medical Doctor? _____

OB/GYN? _____

Dentist? _____

**Habits and Social History**

1. Do you use: Caffeine: Cups per day ____ Tobacco/Packs per day ____
   Alcohol: Drinks per day ____ Recreational Drugs ____
2. Please describe your work:
   Type: __Professional __Physical Labor __Driver __Clerical __Factory
   __Homemaker __Student
   Physical Demands: __Heavy __Moderate __Mild __Sedentary
   Stress Level: __High __Medium __Low
3. Exercise: None ___ Moderate ___ Daily ___ Type? _____
4. Your Diet is: ____Balanced ____Fair ____Poor ____Excessive ____Restricted
5. Medications: Please list all medications (prescription, non-prescription & vitamins/herbs) you are taking or take on an occasional basis:
   _____
   _____
   _____

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## Family History

| Condition | Father Age { } | Mother Age { } | Spouse Age { } | Brother (s) Age { }{ } | Sister (s) Age { }{ } | Children Age { } { } |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problems | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Troubles | | | | | | |
| Liver Problems | | | | | | |
| Lung Disease | | | | | | |
| Migraine | | | | | | |
| Nervousness | | | | | | |
| Neuritis | | | | | | |
| Neuralgia | | | | | | |
| Pinched Nerve | | | | | | |
| Scoliosis | | | | | | |
| Sinus Trouble | | | | | | |
| Stomach Trouble | | | | | | |
| Other: | | | | | | |

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## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed to what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

## Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Premier Chiropractic & Wellness include but may not be limited to:

The Staff of Premier Chiropractic & Wellness. This includes:
_x_ Dr. E. Dean Dierksen
_x_ All Chiropractic Assistants

Necessary health care providers or family members who may need to be consulted if related to the patient's condition. This includes:

_____ _____

_x_ Your Primary Care Physician
Name: _____
Medical Group/Office: _____
City: _____ State: _____ ZIP _____

_____ _____
Patient Signature Date

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1. Have you ever had any previous chiropractic experience?
   ___ Activator ___Acupuncture ___Manual ___None
   Other: _____
2. What is your major symptom?
   _____
3. What does this prevent you from doing or enjoying?
   _____
4. If this is a reoccurrence, when was the first time you noticed the problem?
   _____
   • How did it originally occur? _____
5. Has it become worse recently? __ Yes __ No __ Same __ Better __ Gradually Worse
   If yes, when and how? _____
6. How frequent is the condition? __Constant __Daily __Intermittent ___ Night Only
   How long does it last? All Day ___ A Few Hours ____ Minutes ____
7. Are there any other conditions or symptoms that may be related to your major symptom?
   ___ Yes ____ No If Yes, please describe _____
8. Describe the pain: ___Sharp ___Dull ___Numbness ___Tingling ___Aching
   ___Throbbing ___Tight/Stiff ___Burning ___Stabbing ___Other _____
9. Is there anything that you can do to relieve the problem? ___ Yes ___No
   If yes, please describe: _____
   If no, please let us know what you have tried that didn't work:_____
10. What makes the problem worse? ___Standing ___Sitting ___Lying ___Bending
    ___Lifting ___Twisting __Other: _____
11. List *any* surgeries that you have had:
    _____
12. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form, either in the past or present? ____ Yes ____ No
    • If Yes, please explain: _____
    _____
13. WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?
    Yes _____ No _____ Uncertain _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

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## Informed Consent Chiropractic Care

In coming to Dr. Dierksen, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Dr. Dierksen, of course, will not give any treatment or health care if they are aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. Dr. Dierksen provides a specialized, non-duplicating health care service. Dr. Dierksen is licensed in chiropractic and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by Dr. Dierksen at Premier Chiropractic & Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Initial _____

## Photo/Announcement Release:

I, Patient Name (please print) _____, give Premier Chiropractic & Wellness permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

## Email/Text Appointment Reminders

We try to utilize the most advanced and convenient way to remind you of your appointments. We offer email or text reminders with 24 hour prior notice. Please provide us with your cell phone and carrier to provide text alerts or email address to provide email alerts, or both. You may also opt out of this service by checking below.

Cell Phone Number & Carrier: _____

Email Address: _____ Opt out here: ____

## Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized the appointment time.

Initial _____

_____ _____

**Patient or Authorized Representative Signature** **Date**