

Amelia Chiropractic Clinic, 2888 S. 8<sup>th</sup> St. , Fernandina Beach, FL 32034 (904 321-0002)

**CONFIDENTIAL PATIENT INFORMATION**

FEDERAL AND STATE LAWS REQUIRE ALL HEALTH CARE PROVIDERS TO COLLECT THE FOLLOWING INFORMATION AND KEEP IT ON FILE FOR FOUR (4) YEARS. PLEASE COMPLETE THE FOLLOWING FORMS. THANK YOU.

(PLEASE PRINT)

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELLULAR/PAGER \_\_\_\_\_

ADDRESS \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ MARITAL STATUS M S W D # OF CHILDREN \_\_\_\_\_

OCCUPATION \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_

NAME OF HEALTH PLAN \_\_\_\_\_

**AUTHORIZATION TO PROVIDE TREATMENT AND BILL HEALTH PLAN:**

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. WE UNDERSTAND THAT YOUR HEALTH INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. WE CREATE A RECORD OF YOUR CARE AND SERVICES YOU RECEIVE AT OUR CLINIC. WE NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH FEDERAL AND STATE LAWS. COPIES OF YOUR RECORDS ARE AVAILABLE FOR A NOMINAL FEE. WE WILL MAINTAIN YOUR RECORDS IN ACCORDANCE WITH STATE LAW FOR NO LESS THAN FOUR YEARS.

THE INFORMATION OBTAINED FROM YOU WILL ALWAYS BE HELD IN STRICT CONFIDENCE.

BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO PROVIDE YOU APPOINTMENT CONFIRMATIONS, BIRTHDAY CARDS, AND OTHER SUCH INFORMATION THAT WILL MAKE YOUR TREATMENT MORE ENJOYABLE AND PRODUCTIVE.

I AUTHORIZE THE DOCTORS OF AMELIA CHIROPRACTIC CLINIC TO PROVIDE TREATMENT TO ME. I UNDERSTAND THAT AMELIA CHIROPRACTIC CLINIC WILL VERIFY MY INSURANCE COVERAGE AND PREPARE NECESSARY REPORTS AND FORMS, AND ASSIST IN MAKING COLLECTION FROM MY HEALTH PLAN. BY SIGNING BELOW, I AM AUTHORIZING AMELIA CHIROPRACTIC CLINIC TO RELEASE MY HEALTH INFORMATION INCLUDING MY MEDICAL HISTORY, X-RAY RESULTS, AND PHYSICAL EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS TO MY HEALTH PLAN.

UNFORTUNATELY, THERE IS NO GUARANTEE MY HEALTH PLAN WILL MAKE PAYMENT AND I UNDERSTAND THAT CHARGES FOR TREATMENT ARE ULTIMATELY MY RESPONSIBILITY. ANY AMOUNT PAID BY THE HEALTH PLAN WILL BE PAID DIRECTLY TO AMELIA CHIROPRACTIC CLINIC AND WILL BE CREDITED TO MY ACCOUNT. A SERVICE CHARGE OF 5% PER MONTH WILL BE ASSESSED ON ALL ACCOUNTS OLDER THAN 60 DAYS. ANY FEES NECESSARY FOR THE COLLECTION OF THIS ACCOUNT WILL ALSO BE MY RESPONSIBILITY. IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE.

MY HEALTH PLAN (S) IS HEREBY DIRECTED AND AUTHORIZED TO MAKE PAYMENTS DIRECTLY TO AMELIA CHIROPRACTIC CLINIC.

PATIENT'S SIGNATURE \_\_\_\_\_ SS # \_\_\_\_\_

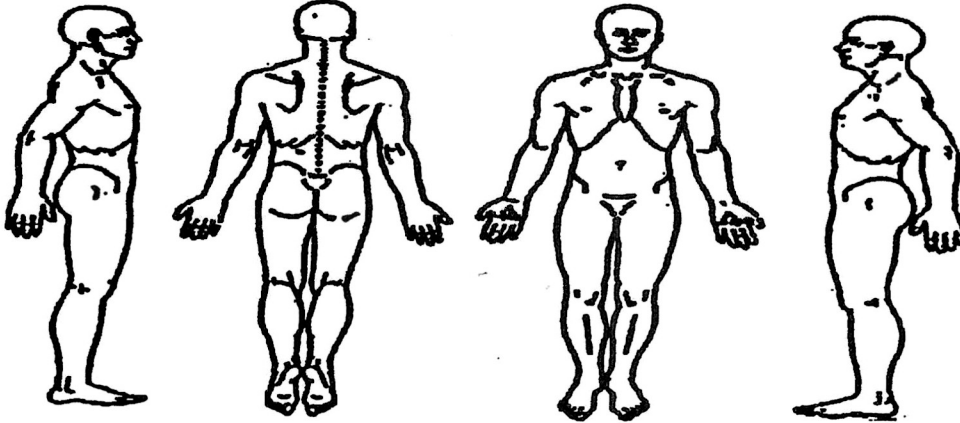
PARENT/ GUARDIAN  
SIGNATURE AUTHORIZING CARE \_\_\_\_\_ DATE \_\_\_\_\_

**Confidential Patient Information**

Patient Name: \_\_\_\_\_

Date \_\_\_\_\_

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

- Constantly (76-100% of the time)     Occasionally (26-50% of the time)     Frequently (51-75% of the time)     Intermittently (1-25% of the time)

3. How would you describe the type of pain?

- |                                  |   |                                   |  |
|----------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Sharp   | <input type="checkbox"/> Numb                 | <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion    | <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion | <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff   | <input type="checkbox"/> Other _____          |                                   |  |

4. How are your symptoms changing with time?

- Getting Worse     Staying the Same     Getting Better

5. Using a scale of 0-10 (10 being the worst), how would you rate your problem?

(please circle) 0 1 2 3 4 5 6 7 8 9 10

6. How much has the problem interfered with your work?

\_\_ Not at all    \_\_ A little bit    \_\_ Moderately    \_\_ Quite a bit    \_\_ Extremely

7. How much has the problem interfered with your social activities?

\_\_ Not at all    \_\_ A little bit    \_\_ Moderately    \_\_ Quite a bit    \_\_ Extremely

8. Who else have you seen for your condition?

- |                                       |  |   |                                       |
|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist       | <input type="checkbox"/> Primary Care Physician | <input type="checkbox"/> ER physician |
| <input type="checkbox"/> Orthopedist  | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Other _____  |

9. How long have you had this problem? (i.e. date of onset?) \_\_\_\_\_

10. How do you think your problem began? (i.e. accident or injury) \_\_\_\_\_

11. What aggravates your problem? \_\_\_\_\_

12. What alleviates your problem?

13. What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_

14. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_

15. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis       Diabetes       Lupus       Heart Problems       Cancer       ALS

16. List all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Any Medical Allergies? \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No

17. Please check any of the conditions below that may apply to you.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Neck Pain                   | <input type="checkbox"/> Heart Attack              |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Smoking/Tobacco Use       |
| <input type="checkbox"/> Excessive Thirst       | <input type="checkbox"/> Angina               | <input type="checkbox"/> Drug/Alcohol Dependence     | <input type="checkbox"/> Kidney Stones             |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Kidney Disorders     | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Bladder Infection         |
| <input type="checkbox"/> Systemic Lupus         | <input type="checkbox"/> Painful Urination    | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Loss of Bladder Control   |
| <input type="checkbox"/> Dermatitis/Eczema/Rash | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Abnormal Weight Gain/Loss |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Loss of Appetite     | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> General Fatigue        | <input type="checkbox"/> Tumor                | <input type="checkbox"/> Loss of muscle coordination | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Visual Disturbances    | <input type="checkbox"/> Chronic Sinusitis    | <input type="checkbox"/> Abdominal Pain              |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Other _____          |  |  |

18. List all surgical procedures you have had: \_\_\_\_\_  
\_\_\_\_\_

19. Have you ever been hospitalized? \_\_\_ No \_\_\_ Yes if yes, why? \_\_\_\_\_  
\_\_\_\_\_

20. What activities do you do at work?

\_\_\_ Sit:                      \_\_\_ most of the day      \_\_\_ Half of the day      \_\_\_ A little of the day

\_\_\_ Stand:                      \_\_\_ most of the day      \_\_\_ Half of the day      \_\_\_ A little of the day

\_\_\_ Computer Work:      \_\_\_ most of the day      \_\_\_ Half of the day      \_\_\_ A little of the day

\_\_\_ On the Phone:              \_\_\_ most of the day      \_\_\_ Half of the day      \_\_\_ A little of the day

21. What activities do you do outside of work? \_\_\_\_\_  
\_\_\_\_\_

22. Have you had significant past trauma? \_\_\_ No \_\_\_ Yes

23. Anything else pertinent to your visit today?  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Unbearable pain

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

## Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

## Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

## Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

## Section 4 – Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

## Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

## Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

## Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

## Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

## Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

## Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL \_\_\_\_\_

## The Neck Disability Index

Patient name: \_\_\_\_\_ File# \_\_\_\_\_ Date: \_\_\_\_\_

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

### SECTION 1-PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

### SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

### SECTION 4-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

### SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

### SECTION 6-CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

### SECTION 7-WORK

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 8-DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

### SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

### SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

**Amelia Chiropractic Clinic**

2888 S. 8<sup>th</sup> Street, Fernandina Beach, FL 32034 \* Tel (904) 321-0002

**INSURANCE AUTHORIZATION**

I AUTHORIZE THE DOCTORS OF RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** TO PROVIDE TREATMENT TO ME. I UNDERSTAND THAT RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** WILL VERIFY MY INSURANCE COVERAGE AND PREPARE NECESSARY REPORTS AND FORMS, AND ASSIST IN MAKING COLLECTION FROM MY HEALTH PLAN. BY SIGNING BELOW, I AM AUTHORIZING RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** TO RELEASE MY HEALTH INFORMATION INCLUDING MY MEDICAL HISTORY, X-RAY RESULTS, AND PHYSICAL EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS TO MY HEALTH PLAN.

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MY HEALTH PLAN (S) IS HEREBY DIRECTED AND AUTHORIZED TO MAKE PAYMENTS DIRECTLY TO RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC.**

**PATIENT'S SIGNATURE**\_\_\_\_\_

**PARENT/ GUARDIAN  
SIGNATURE AUTHORIZING CARE**\_\_\_\_\_

**DATE**\_\_\_\_\_

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# *Amelia Chiropractic Clinic*

## **Informed Consent to Chiropractic Treatment**

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your spine. Various therapeutic procedures, such as hot or cold packs, electric muscle stimulation, or therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The therapeutic procedures could produce skin irritation, burns or minor complications. Should you have questions you will be given the opportunity to discuss them with the doctor before you receive treatment.

Probability of risks occurring: The risk of complications due to chiropractic treatment have been described as "rare", about as often as complications from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be further reduced by screening procedures. The probability of adverse reaction due to therapeutic procedures is also considered "rare."

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers and analgesics. Risk of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo chiropractic treatment, and hereby give my full consent to treatment. I intend this agreement to be in effect for all treatments from the date signed until I curtail treatment at this facility.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**ACKNOWLEDGMENT OF RECEIPT  
OF  
RD RICE CHIROPRACTIC, DBA AMELIA CHIROPRACTIC CLINIC  
NOTICE OF PRIVACY PRACTICES**

**Patient Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_

I, the undersigned, acknowledge that I have been made aware that I have been offered the opportunity to review the **Notice of Privacy Practices** from RD Rice Chiropractic, DBA Amelia Chiropractic Clinic, which explains how my medical information will be used and disclosed, and how I can get access to this information. I also acknowledge that I am entitled to a copy of this Notice of Privacy Practices upon request.

I understand that the Notice of Privacy Practices may be revised periodically and that I can request a copy of any revisions by contacting the practice.

I also understand that if I have any questions regarding the Notice of Privacy Practices, I can contact the Privacy Officer at 904-321-0002 or in writing at Amelia Chiropractic Clinic 2888 S 8<sup>th</sup> Street, Fernandina Beach, FL 32034.

By signing below, I acknowledge that I have received and reviewed a copy of this notice.

**I also give [name of practice] permission to:**

- Leave a message on my answering machine or voicemail.  
    \_\_\_ Yes    \_\_\_ No
- Confirm appointments by leaving messages or speaking with family.  
    \_\_\_ Yes    \_\_\_ No
- Leave Pre-medication reminders (if applicable).  
    \_\_\_ Yes    \_\_\_ No
- Speak with the following family members regarding my care?  
    \_\_\_ Yes    \_\_\_ No
- Names of family members the practice may speak with regarding my care:

\_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**If signed by a personal representative, please complete the following:**

**Personal Representative's Name:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_  
**Signature of Personal Representative:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

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*Amelia Chiropractic Clinic*

2888 South 8th Street  
Fernandina Beach, FL 32034  
(904) 321-0002 (voice & fax)

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please release my x-rays and medical records to:

The Amelia Chiropractic Clinic  
2888 S. 8<sup>th</sup> Street  
Fernandina Beach, FL. 32034  
(904) 321-0002

\_\_\_\_\_  
Signature

Name of Patient (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

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**Amelia Chiropractic Clinic**

**2888 S. 8<sup>th</sup> Street, Fernandina Beach, FL 32034 \* Tel (904) 321-0002**

**“NO-SHOW” APPOINTMENT POLICY**

We schedule our appointments so that each patient receives the right amount of time to be seen by our doctors and staff. That’s why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy and to help patients remember their scheduled appointments, Amelia Chiropractic Clinic places reminder telephone calls 2 to 3 days in advance of your appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as those patients who are waiting to schedule with the doctor, please give us at least 24 hour notice.

If you do not cancel or reschedule your appointment with at least 24 hour notice, we may access a minimum fee of \$25.00 “no show” service charge to your account. This “no show charge” is not reimbursable by your insurance company. You will be billed directly for it.

After three no-show appointments, our practice may decide to terminate its relationship with you.

Thank you for your consideration of our “no-show” policy and for the opportunity to be your Chiropractic office of choice.

I understand the “no-show” policy of Amelia Chiropractic Clinic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

# EHR Certification – Patient Information 4

Dear Patient: The US government is now requiring that we supply them with the following information:

## PATIENT DEMOGRAPHICS:

Name: (Print clearly) \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino
--------------------	------------------------

Race: (Circle all that apply)

White	American Indian/ Alaskan Native	Black/African American
Asian	Native Hawaiian/ Pacific Islander	

Please list health history, the condition and the relative (i.e., Mother, Father, Sister, Brother, Son Daughter, etc.)

Health Condition	Relative

If there is an emergency, in which language would you like to receive the message?

What is your preferred method of contact?

Home	Work	Cell
------	------	------

Phone Number: \_\_\_\_\_

Phone Call:  Text:  E-Mail:

Email Address: \_\_\_\_\_

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name? (Answer must have at least six characters):

Secret Question: \_\_\_\_\_

Secret Answer: \_\_\_\_\_

## OFFICE USE ONLY

Vitals: In EZnotes, complete by  
1) Going to "Exam" screen  
2) "Select by region"  
3) Then select "Vitals"

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Smoking Status:**

Smokes everyday	Smokes some days	Former Smoker	Never Smoked
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If you smoke, how many cigarettes do you smoke per day? \_\_\_\_\_

**PRESCRIBED MEDICINES**

Check here if not taking any medications:

<b>Medication:</b> i.e. Lipitor	<b># of MD refills issued:</b>	<b>Quantity of Pills:</b>	<b>Strength: i.e.</b> 10 mg	<b>MD's instruction:</b> i.e. 1 per day

**Are you allergic to any medicines? Please list each drug on a new line:**

Check here if you do not have any medical allergies:

<b>Name of Drug: i.e.</b> penicillin	<b>Symptom: i.e.</b> headache	<b>Severity: i.e.</b> Mild, Moderate, Severe, Fatal

**Even though the Federal Government suggests that I apply for a Microsoft Health Vault account, I would prefer not to: (Please check box to opt out)**

**OFFICE USE ONLY**

Entered into EZnotes by (name): \_\_\_\_\_ Date & Time: \_\_\_\_\_ Completed? \_\_\_\_\_