

PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Date: _____
 Patient: _____ Date of Birth: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Social Security No.: _____ Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email: _____
 Employer: _____ Address: _____
 Name of Spouse: _____ SS No.: _____ No. of Children: _____
 Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____
 Nearest relative not living with you? _____ Phone: _____
 Who is responsible for payment? Self Spouse Other _____

PATIENT'S INSURANCE	SPOUSE'S INSURANCE
Name of Company: _____	Name of Company: _____
Address: _____	Address: _____
ID & Group No.: _____	ID & Group No.: _____
Phone No.: _____	Phone No.: _____

Purpose of this appointment and list your complaints: _____

 Date of illness: _____ Time: _____ AM PM Location: _____
 How did accident occur? Auto On the job Other: _____
 Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____
 Have you been treated by a Doctor for any health condition in the last year? Yes No
 If Yes, please describe? _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account upon receipt. However, 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.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?
 YES NO

GASTRO-INTESTIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

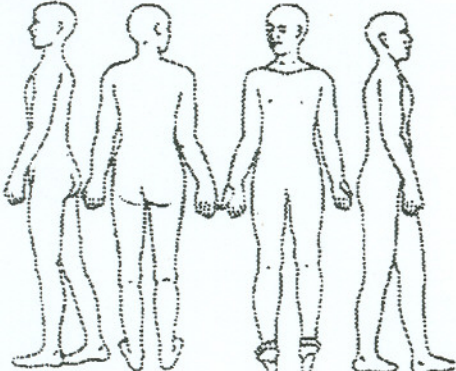
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

Authorization for the Use or Disclosure of Protected Health Information

Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145

Office (918) 493- 1493 Fax (918) 576-6789

As required by the Health Insurance Portability and Accountability Act of 1996 Bovadilla Chiropractic Clinic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize Dr Bovadilla the use or disclosure of the following health information that pertains to me.

ALL Medical Information History and Physical X-Ray Reports X-Ray Images
 Lab Reports Operative Report Discharge Summary Consultation Reports
 Other(explain) _____

for the following purpose<s>: Continue Treatments Request of patient or their legal representative Other _____

I authorize the following persons or organization to the use or disclosures of my health information:

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire when information is release or obtained or one year after the date signed whichever comes first.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

Signature

Date

REVOCAION SECTION

I hereby revoke this authorization.

Signature

Date