LEONARD J. CIANCIOLO, D.C.
DOCTOR OF CHIROPRACTIC
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CASE HISTORY

NAME:_____ **DATE:**_____
ADDRESS:_____ **REFERRED BY:**_____
_____ **EMERGENCY CONTRACT:**_____
PHONE#: ( ) _____ - _____ _____
DATE OF BIRTH:___/___/___ **PHONE#:** ( ) ___ - _____
SEX: M / F AGE:_____ **STATUS: M S W D**
PERSON RESPONSIBLE FOR THIS ACCOUNT:_____
SOCIAL SECURITY:_____ **SPOUSES NAME:**_____
EMPLOYER:_____ **INSURANCE INFORMATION:**
ADDRESS:_____ **WILL YOU BE USING YOUR INSURANCE?**
_____ **YES NO**
PHONE#:( )____ - _____ **NAME OF INSURANCE:**_____
OCCUPATION:_____ **I.D.#:**_____
CELL NUMBER _____ **PERSON INSURED:**_____
What are your major complaints?_____
_____
How long have you had this condition?_____
Is the condition getting: Better Same Worse Constant Comes and Goes
List all doctors you have seen for this condition:_____
_____
What treatment was given?_____
Have you had X – Rays taken before? Y N What type?_____
Are you currently taking any medications? Y N Which ones?_____
_____
Are you Pregnant? Y N Due Date? ___/____/____
List all surgical operations you have had and when you had them:_____
_____
Is this condition due to an auto or work related accident?_____

PATIENT CONSENT

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires our office to obtain written patient consent before disclosing Protected Health Information (PHI). We respect the privacy of your health care information. Below is a list of circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to other healthcare providers or hospitals for assessment,diagnosis, or treatment to your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of services (ie; Insurance Co., Attorney, Third Party Liability).
- We may need to use your health information within our practice for quality control or other operation purposes.

We have a HIPAA Office Log which provides a detailed description of how your health information may be used or disclosed. You have the right to limit uses or disclosures of your health information. You may also revoke your consent at any time in writing.

I have read your consent policy and agree to its terms.

_____ _____ _____
PATIENT SIGNATURE DATE SIGNED WITNESS SIGNATURE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors of chiropractic who are now, or in the future, employed at the clinic or office.

I have had an opportunity to discuss with the doctor of chiropractic, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and, by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____ _____/_____/_____

Patient's Signature Date

_____

Patient's Name Printed

/consent