Dobsch Chiropractic & Family Wellness, L.L.C.
Samantha L. Dobsch, D.C.

ALL INFORMATION BELOW **MUST** BE COMPLETED

Date:______________________

Patient Information

First Name	**Middle Initial**	**Last Name**	**Birthdate** / /
Street Address			Apt.
City	**State**	**Zip Code**	**Home Phone** ( )
Work Phone ( )	**Cell Phone** ( )	E-Mail	
Work / Student Status FT PT	Employer/ School	Occupation	
Sex M F	**Race** Caucasian ( ) African American ( ) Decline to State ( ) Other: ________________		
Marital Status S M D W	# of Children	**Spouse's Name**	**Parent's Name (If minor)**
Ethnicity Not Hispanic or Latino ( ) Hispanic or Latino ( ) Decline to State ( )			**Language** English ( ) Other: ________________

Insurance Information

Primary Insurance	Member's Name	Birthdate / /	Relationship to Member
Address of member (If not same as above)			Employer

Secondary Insurance	Member's Name	Birthdate / /	Relationship to Member
Address of member (If not same as above)			Employer

Who referred you to the office? ____

Emergency Contact ____________________________ Relationship__________________ Phone (_______)______________________

Nearest relative
NOT living with you ____________________________Relationship__________________ Phone (_______)______________________

*I approve all of the above information is correct and has been completed to the best of my ability.

PATIENT SIGNATURE: ____ DATE:____________________

NAME ____ **DATE** ____________________

SYMPTOMS / HISTORY

Describe, **in detail**, your symptoms: ____

____

History of this condition & doctors you have seen for it: ____

____

Injury _____ Gradual Onset _____ When did your symptoms start: ____________________

Medical Doctor: ______________________________ Last Physical: ____________________

X-ray/MRI/CT taken within past 5 years (when & where): ____________________

List any surgeries & when: ____

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Broken Bones: ____

Auto accidents, list injuries & dates: ____

Over-the-counter Medications: ____

Prescription Medications: ____

Medication Allergies: ____

Conditions that you are receiving ongoing treatment for (heart condition, diabetes, cancer, etc.): ____________

____

(Women only) Are you pregnant? ____ yes ____ no Nursing? ____ yes ____ no

Taking birth control pills? ____ yes ____ no

DAILY HABITS

Average alcohol consumption: ____

Average caffeine consumption (coffee, soda, tea, etc.): ____

Smoking Status: _____ Every Day _____ Social _____ Former _____ Never

Do you take daily vitamins? ____ yes ____ no What type? ____________________

HEALTH HISTORY (Mark "F" for immediate family member - Please also indicate *mother, father, sister or brother* - and mark "S" for yourself)

- ☐ AIDS / HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other

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Dobsch Chiropractic & Family Wellness, L.L.C.

Samantha L. Dobsch, D.C.

1190 Jefferson St. Ste. 203
Washington, MO 63090
(636) 239-3265

102 One Street
Marthasville, MO 63357
(636) 229-1825

ATTENTION: Please read all information below prior to signing. It is important that you understand the information contained in this document. Please ask questions if anything is unclear.

Consent to Treatment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy by hand or Activator. The undersigned does hereby authorize the physician(s) to permit therapy, manipulation, diagnostic testing, examination, and x-rays as recommended by the physician(s). No guarantees are made as to the results of treatments or examinations.

Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. Complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur 1 in 1 million and 1 in 5 million cervical adjustments. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that otherwise not come to my attention, it is your responsibility to inform me.

Agreement for Payment

In consideration of the rendering of services at Dobsch Chiropractic & Family Wellness, L.L.C., the undersigned (whether signing as the patients, or as parent, legal guardian, spouse or representative of the patient) do hereby expressly agree to pay and guarantee payment in full of any and all charges for services rendered and materials received to or for the patient of Dobsch Chiropractic & Family Wellness, L.L.C.

Authorization for Release of Information/Records

The undersigned herby authorizes Dobsch Chiropractic & Family Wellness, L.L.C. to furnish the patient's insurance carrier(s) or insurance carrier(s)'s representative potentially liable for payment of charges arising from all treatment, any medical information, or statement of charges as might be requested by said insurance carrier(s). Dobsch Chiropractic & Family Wellness, L.L.C. is authorized to furnish this information for any services provided by this office or for any physician services provided to the patient.

Assignment of Insurance Benefits

In consideration for the rendering of services by Dobsch Chiropractic & Family Wellness, L.L.C., the undersigned do hereby assign benefits of any type arising out of any policy of insurance insuring the patient or any other party liable to patient which covers treatment directly to Dobsch Chiropractic & Family Wellness, L.L.C.

Member of Health Maintenance Organizations and preferred provider organizations are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admissions, pre-certification, and utilization review. These are conditions to payment of Dobsch Chiropractic & Family Wellness, L.L.C.'s billed charges rendering in any case in which payment may be denied by the health maintenance organization or preferred provider organization, because of a failure to comply with such coverage requirements or for any other reason.

I have read the above and understand the risks and herby give my consent for treatment and services provided by Dobsch Chiropractic & Family Wellness, L.L.C.

DATE ______ /______ /______ PRINT NAME:____

SIGNED: ____

DOBSCH CHIROPRACTIC & FAMILY WELLNESS, L.L.C.

SAMANTHA L. DOBSCH, D.C.

PROTECTED HEALTH INFORMATION
AUTHORIZED PERSON(S)

Please PRINT below information

I, ________________________________, hereby authorize release of my Protected Health Information for verbal discussion only of my care and treatment to the person(s) specified below:

Authorized family member or person to receive information for the above named patient's care:

Name of Primary Contact (other than self)	Relationship to Patient	Phone Number

Others authorized to receive my verbal information (please list names and relationship):

Print Name	Relationship to Patient	Phone Number

Print Name	Relationship to Patient	Phone Number

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

- **May we leave a message on your answering machine or voicemail?** **YES** **NO**
  (Example: We may leave message reminders, scheduling changes, or billing/insurance inquiries. Would this process be acceptable?)
- **May we leave a message for patient to return call?** **YES** **NO**
  (Example: We may leave a message regarding an appointment or billing/insurance inquiries with an individual who answers the phone. Would this process be acceptable?)

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Dobsch Chiropractic & Family Wellness, L.L.C. I understand that the Notice describes the uses and disclosures of my protected health information by Dobsch Chiropractic & Family Wellness, L.L.C. and informs me of my rights with respect to my protected health information.

Patient Signature ____ Date ________________

Personal Representative __________________________________ Relationship to Patient _____________