

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # SS#

Patient Name \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with  \_\_\_\_\_ and assign directly to  
 Name of Insurance Company(ies) \_\_\_\_\_

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_ Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

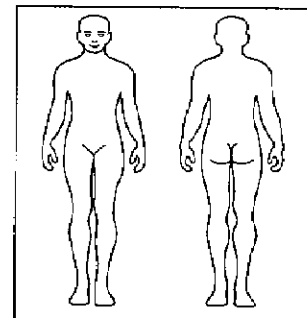
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications     Surgery     Physical Therapy  
 Chiropractic Services     None     Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                     |                              |                             |                  |                              |                             |                     |                              |                             |                      |                              |                             |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| AIDS/HIV            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chicken Pox      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____          |                              |                             |
|                     |                              |                             | Kidney Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |

<p><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <input type="checkbox"/> Smoking                      Packs/Day _____ <input type="checkbox"/> Alcohol                              Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks          Cups/Day _____ <input type="checkbox"/> High Stress Level                  Reason _____
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Are you pregnant?  Yes     No    Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

**Winterbottom Family Chiropractic, LLC**  
**Chad Winterbottom, D.C.**  
**Ernest Winterbottom, D.C.**  
Brickworks Office Park  
5429 Harding Highway (Route 40)  
Mays Landing, NJ 08330

**Consent for Purposes of Treatment, Payment & Healthcare Operations**

In this document, "I" and "my" refer to the patient,  
and "Chiropractor(s)" refers to **Winterbottom Family Chiropractic, LLC.**

I consent to the use or disclosure of my protected health information by Chiropractor(s) for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor(s). I understand that analysis, diagnosis or treatment of me by Chiropractor(s) may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor(s) is not required to agree to the restrictions that I may request. However, if Chiropractor(s) agrees to a restriction that I request, the restriction is binding on Chiropractor(s). I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor(s) has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor(s) and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor(s). The Notice of Privacy Practices for Chiropractor(s) is also posted in the waiting room at Winterbottom Family Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor(s) with respect to my protected health information.

Chiropractor(s) reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor(s) and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority

**WINTERBOTTOM FAMILY CHIROPRACTIC, LLC**

Chad Winterbottom, D.C.  
Ernest Winterbottom, D.C.  
5429 Harding Hwy. (Route 40) – Suite #201  
MAYS LANDING, NJ 08330

TEL: 609-625-2006  
FAX: 609-625-1995

To:

This will authorize all Hospitals, Doctors, Attorneys and Employers to furnish to Winterbottom Family Chiropractic, LLC, at the above address, all information, medical reports and records pertinent to:

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

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

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

\* Photocopy shall be considered as effective and valid as the original.

Comments:

\*I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Dr. Winterbottom. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

\* I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Winterbottom.