Augello Chiropractic
1578 Easton Avenue
Bethlehem, Pa 18017

* ENTRANCE RECORD *

(PLEASE ANSWER ALL QUESTIONS. YOUR ANSWERS ARE CONFIDENTIAL.)

Name (Print)_____Date_____E-mail_____

Address (Street)_____(City)_____

(State)_____(Zip)_____Spouse's First Name_____

Telephone Number (Home)_____(Work)_____(Cell)_____

Occupation_____Employer_____

Birth date (Month)_____(Day)_____(Year)_____Age_____Social Security #_____-_____-_____

Spouse's Birth Date (Month)_____(Day)_____(Year)_____Spouse's Soc Sec # _____-_____-_____

Family Physician:_____(Phone)_____

Height:_____Weight_____

Referred By:_____

* HEALTH HISTORY*

Is your problem due to a ☐ Motor vehicle accident or ☐ Work injury? ☐ No / Date of Accident/Injury_____

Please describe your current pain, its location, the severity, and when it began in detail:_____

_____

_____

Have you had this condition in the past? ☐ Yes ☐ No. If Yes, when?_____

Is the pain getting: ☐ worse ☐ better ☐ same ☐ comes and goes How often do you have this pain?_____

Have you ever been to any other doctor(s) with this particular problem? ☐ Yes ☐ No _____

If yes, who and what treatment did you receive?_____

Have you been to a chiropractor before? ☐ Yes ☐ No If yes, when, why, _____

_____

Patient Name:_____Date:_____DOB:_____

Due to recent changes in the healthcare industry, we are asked to obtain the following information on patients treated in our office.

General Information:

Language: ____English ____ Spanish ____ Indian ____ Japanese ____ Chinese ____ Korean ____ French ____ German ____ Russian ____ Other_____

Race: ____ White ____American Indian or Alaska Native ____ Asian
____Native Hawaiian/Other Pacific Islander ____ Black or African American
____ Hispanic or Latino ____ Decline to Answer

Ethnicity: ____ Hispanic or Latino ____Not Hispanic or Latino ____ Decline to Answer

We may need to contact you, check which option you prefer us to use when contacting you:
Contact Preference: ____Hm Ph ____Wk Ph ____Cell Ph ____ Text Msg ____ Mail
____Hm Email ____Wk Email

Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____
_____
_____

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	☐	☐	_____
...been diagnosed with Diabetes Type I___or Type II____	☐	☐	_____

Vitals (for office use only- completed by staff-move to smoking question & complete the questionnaire)
Height _____ Weight _____ Blood Pressure _____

Do you smoke? ☐Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by
Please be as specific as possible

_____
_____
_____
_____
_____

Do you have allergies? ☐Food ☐Environmental ☐Medication
List Type of Allergy and Reaction

_____
_____
_____

ENTRANCE RECORD (CON'T)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness

☐ Cramping ☐ Stiffness ☐ Swelling ☐ Going into arm ☐ Going into leg

Activities/movements that are difficult/painful to perform:

☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting ☐ Standing ☐ Sleeping ☐ Driving

Do you have any of the following problems?

☐ Headaches ☐ Cancer ☐ HIV ☐ Gout ☐ Stroke ☐ Heart Disease ☐ Diabetes ☐ Arthritis

☐ Dizziness ☐ Nervousness ☐ High Blood Pressure ☐ Fatigue ☐ Digestive difficulty

☐ Fainting/Seizures/Epilepsy ☐ Jaw pain ☐ Difficulty breathing ☐ Earaches ☐ Ringing in ears

☐ Kidney pain ☐ Psychiatric problem ☐ Other:_____

If yes to Headaches how often? Describe:_____

Family history: ☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Spinal Condition ☐ Other:_____

Did you have surgery? ☐ None ☐ Appendix ☐ Hernia ☐ Gallbladder ☐ Thyroid ☐ Spine ☐ Heart

☐ Joint Replacement ☐ Other:_____When?_____

Check: ☐ Accidents ☐ Falls ☐ Fractures ☐ Dislocations ☐ Head Injuries When?_____

Do you smoke? ☐No ☐Yes, how much?_____ Do you drink alcohol? ☐No ☐Yes, how much?_____

Please list any medications and/or vitamins you are taking and the reason?(Include non-prescription, muscle relaxants, birth control, etc.)_____

_____

Have you had any: ☐ X-rays ☐ MRI ☐ CT Scan ☐ Other What area of body?_____

If yes, When was test taken? _____Where was test performed?_____

Are you pregnant? ☐ No ☐ Yes how far along?_____Nursing? ☐ Yes ☐ No

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610-866-4440

MEDICAL INFORMATION RELEASE

I HEARBY AUTHORIZE THE RELEASE of all my medical records to Augello Chiropractic. I also give my permission to Augello Chiropractic to release my medical records to all health care providers who are treating me or may treat me in the future.

Signature_____Date_____

AUTHORIZATION OF BENEFITS

I HEREBY AUTHORIZE PAYMENT of medical benefits directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to Augello Chiropractic. In the event that this account is placed for collections you will be assessed a collection fee and you will be responsible for any attorney fees, cost of collections and recovery fees. These fees will be added to your outstanding balance.

Signature_____Date_____

Augello Chiropractic

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____

Patient #:_____Social Security #:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at any time by contacting:

Contact Person: **Tracey Williams**
Telephone: **(610) – 866-4440 Fax: (610)866-5671**
Address: **1578 Easton Avenue, Bethlehem, PA 18017**

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Augello Chiropractic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____