Odette & Corne Chiropractic

20960 Allen Rd. Brownstown, MI 48183 (734) 479-5130

EMERGENCY CONTACT SHEET

Patients Name _____

1st Contact _____ Relation _____

Address _____

_____

Phone: _____

2nd Contact _____ Relation _____

Address _____

_____

Phone: _____

PATIENT ACKNOWLEDGEMENT HIPPA PRIVACY

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

AUTHORIZATION, ASSIGNMENT & RELEASE FORM
AUTHORIZATION & ASSIGNMENT

In consideration of your undertaking to come to me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, or of the proceeds of any settlement of my case, and/or by any insurance company obligated to make the payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (then name (s) of which is believed to be correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this State of Michigan.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ X_____
Date Patient/Insured Signature

RECORDS RELEASE

To, _____, I hereby authorize you to release to _____
Any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

_____ X_____
Date Patient/Insured Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached a pre-accident status or maximum medical improvement. I further understand that all expenses incurred after the date below will be my responsibility. I will make financial arrangements for payment directly.

X_____ _____ X_____
Patient Signature Date Staff Signature

ODETTE CHIROPRACTIC FAMILY HEALTH CENTER

Patient Name_____ Email_____

Street Address_____ Phone _____

City_____ State_____ Zip_____ Date of Birth_____

Social Security #_____

If patient is a child: Fathers Name _____ Mothers Name _____

Employer _____ **Work Phone** _____

Insurance Name: _____ **Subscribers Name** _____

Group Name or # _____ **Contract #** _____

Where did you hear about our clinic or who referred you? _____
Please Check Sex: Male___Female___ Married___ Single___

Health History:
Give reason for seeking chiropractic care: _____
_____
Describe any health problems, including how long you've had them: _____
_____
Are you under the care of any other doctor? Yes___ No ___
If Yes, the conditions being treated for: _____
List any current Medications: _____
List any past surgeries & dates: _____
List any past accidents & dates: _____

Females: Is there any possibility of you being pregnant? Yes ___ No ___

Personal & Family History:
Spouse's Name _____ **Employer** _____
Spouse's health status _____
Children's ages and health status: _____

Chiropractic History:
Have you ever been to a Chiropractor before? Yes ___ No ___ If yes Doctor's Name _____
Date of last chiropractic visit _____ **Reason for care** _____
Date of last chiropractic x-rays _____ **How long were you under care?** _____
Reason you discontinued care _____
Are other family members under chiropractic care? Yes ___ No ___ Who? _____

Wellness Commitment
At Odette Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

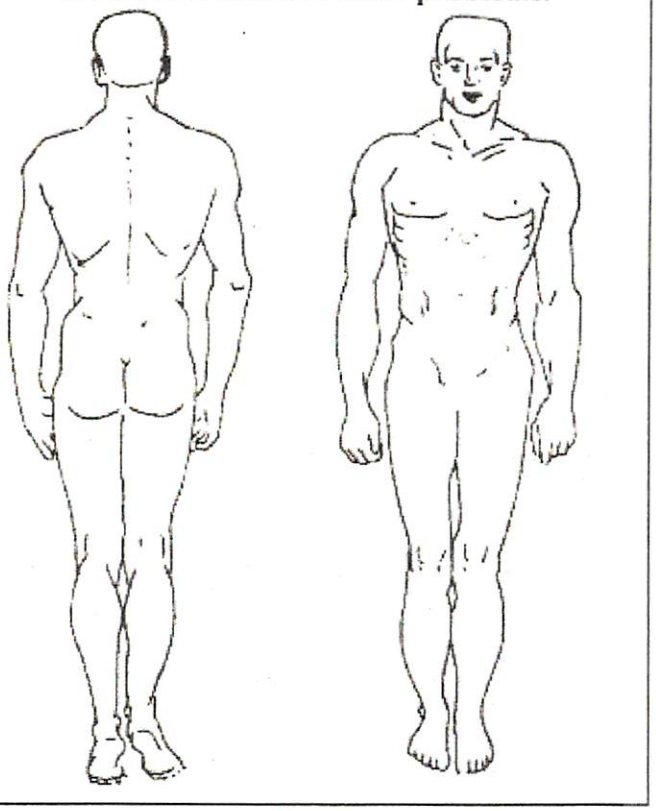
10% ---- 20% ---- 30% ---- 40% ---- 50% ---- 60% ---- 70% ---- 80% ----90%----100%

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Vision Changes	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Frequent colds	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

Odette & Corne Chiropractic

Family History:

Please tell us about the health of your parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write the cause.

	Living/Decease	Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease	
Father	L D Cause:									
Mother	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									

Past and Social History:

Are you employed Y N Where _____How is your health _____

Do you drink alcohol Y N Use tobacco Y N Use recreational drugs Y N

Have you had any illnesses in the past? _____

Have you had any injuries? _____

Have you been hospitalized _____

Have you had any surgeries _____

List any medications that you are taking _____

I certify that the information I have given here is true and accurate to the best of my knowledge

Signed _____ Date _____