Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc

242 E Milltown Rd, Wooster, OH 44691, (330)345-4440

PATIENT INFORMATION – MINOR

First Name_____ MI___Last Name_____ Date_____

Address_____City_____ST_____Zip_____

Home Phone#_____Work#_____Cell#_____

Birth Date_____ Age _____ Email: _____ Gender: Male Female

Social Security_____ Parent or Guardians Name:_____

Family Physician and Clinic:_____

Do we have permission to discuss this case with another family member Y or N Whom:_____

Whom may we thank for referring you to our office_____

Person financially responsible for this account _____

Mother_____ Father_____

Phone#_____ Phone#_____

Address_____ Address_____

_____ _____

DOB_____SS#_____ DOB_____SS#_____

Place of Emp_____ Place of Emp_____

Email _____ Email _____

INSURANCE INFORMATION

Ins. Co. Name_____
Policy#:_____
Group#:_____

Subscriber's Name: _____

Subscriber's Birth Date: _____
Subscriber's SS#:_____

Employer of Insured:_____
Address of Employer:_____
_____

Secondary Ins._____
Policy#:_____
Group#:_____

Subscriber's Name: _____

Subscriber's Birth Date: _____
Subscriber's SS #:_____

Employer of Insured:_____
Address of Employer: _____
_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your Protected Health Information (PHI) in the following ways:

Without your signed authorization
Chiropractic treatment
Payment (cash, insurance, worker's compensation, personal injury)
When release is required by law, including in judicial settings and to health oversight regulatory agency and law enforcement
In emergency situations or to avert serious health/safety situations
To medical examiners, coroner or funeral directors to aid in identifying you or to help them in performing their duties.

Special Cases

To contact you about appointment reminders, treatment alternatives and other health related benefits and services

Other

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights

Restrictions: To request restricted access to all or part of the PHI, write specific information on your patient information and contact our insurance department. We are not required to grant your request.
Confidential Communication: To receive correspondence of confidential information by alternate means or location, contact our insurance or front desk department.
Access: To inspect or receive copies of your PHI, you must sign a consent form.
Amendments: To request changes made to your PHI, contact our insurance department. We are not required to grant your request.
Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request, contact our insurance department.
This Notice: To get updates or reissue of this notice, contact our front desk department.
Complaints: Complaints to PPM/Chaffee Chiropractic Clinic or the U.S. Department of Health & Human Services. If you feel your privacy rights have been violated, register your complaint in writing to Dr. Bryce Chaffee. The law forbids us from taking retaliatory action against you if you complain.

Our Duties

We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact

For more information about our privacy practices, please contact this clinic at:
PPM/Chaffee Chiropractic Clinic Inc, 242 East Milltown Road, Wooster, Ohio 44691, (330) 345-4440
Effective date: April 14, 2003

I acknowledge receipt of this notice:

_____	_____	_____
Patient or Authorized Signature	**Printed Name**	**DOB**

If you are signing as the patient's representative:

_____	_____	_____
Patient's Printed Name	**Relationship to Patient**	**Date**

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

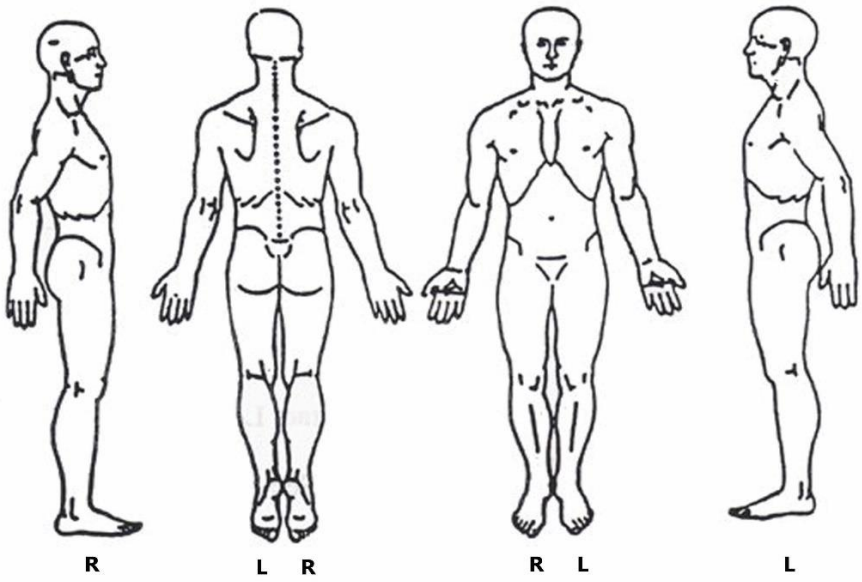
I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **PPM/CHAFFEE CHIROPRACTIC CLINIC INC, DR BRYCE CHAFFEE, DR TAMI CHAFFEE, CHRISITNA COOK, CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ _____/_____/_____
(patient signature) DOB

X_____ X_____
(signature of Guardian if applicable) (please print patient name)

Health History

Patient Name: _____ DOB: _____ /_____ /_____ DATE: _____ / _____ /_____



By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache

Describe your symptoms: _____

_____

When did your symptoms start? _____

How often do you experience your symptoms?

Constantly (76-100% of day) Frequently (51-75% of day) Occasionally (26-50% of day) Intermittently (0-25% of day)

What describes the nature of your symptoms?

Sharp Dull Ache Numb Shooting Burning Tingling Stabbing

How are your symptoms changing?

Getting Better Not changing Getting worse

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework)

Not at all A little bit Moderately Quite a bit Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

All of the time Most of the time Some of the time A little of the time None of the time

In general, would you say your overall health right now is…

Excellent Very good Good Fair Poor

Patient Name: _____ DOB: _____ /_____ /_____ DATE: _____ / _____ /_____

PAST MEDICAL HISTORY

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO YES	Anemia……..NO	YES	Back Trouble……..NO	YES	Hepatitis……..NO	YES
Mumps……	NO YES	Bladder Infection……..NO	YES	High Blood Pressure……NO	YES	Ulcer……..NO	YES
Chicken Pox……	NO YES	Epilepsy……..NO	YES	Low Blood Pressure…….NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO YES	Migraine Headaches..NO	YES	Hemorrhoids……..NO	YES	Thyroid Disease……NO	YES
Scarlet Fever…….	NO YES	Tuberculosis……..NO	YES	Date of Last Chest X-Ray_____		Bleeding Tendency…….NO	YES
Diphtheria……..NO	YES	Diabetes……..NO	YES	Asthma……..NO	YES	Any Other Disease…….NO	YES
Small pox……..NO	YES	Cancer……..NO	YES	Hives of Eczema……..NO	YES	(Please List):	
Pneumonia…….	NO YES	Polio……..NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	_____	
Arthritis…….	NO YES	Hernia……NO	YES	Bronchitis……..NO	YES		
Venereal Disease…	NO YES	Blood or Plasma Transfusion……..NO	YES	Mitral Valve Prolepses….NO	YES	_____	
				Stroke……NO	YES		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____

Allergies _____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			
Excessive Exposure At home or at work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Patient Name: _____ DOB: _____ /_____ /_____ DATE: _____ / _____ /_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____/_____/_____

Signature of the Patient, Parent or Guardian Date

_____ _____/_____/_____

Signature of Doctors Review Date