Hillcrest Chiropractic Associates

Date:_____

Name (Full Legal) _____ Cell Home Phone:_____

Address:_____ City:_____ State/Zip_____

Age:_____ Birth Date:_____ How many children?_____

Occupation:_____ Employer:_____

Address:_____ Office Phone:_____

Guardian or Spouses name:_____ Birth Date:_____

Occupation:_____ Employer:_____

Patients nearest relative or friend (not living at the same home):_____

Address:_____

Referred by (doctor, friend, or family member):_____

Purpose of this appointment (major complaint):_____

Is condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened:_____

Have you lost any days from work? Y____ N____ Is this condition getting progressively worse? Y____ N_____ Constant _____ Comes and goes_____

Is this condition interfering with your: Work____ Sleep_____ Daily routine____ Other_____

Other doctors seen for this condition:_____

Patient ever had the same or similar condition? Y_____ N_____

If yes, when and describe:_____

Date of last physical exam:_____ Female: Are you pregnant? _____

What operations have you had:_____

Serious illnesses:_____ Fractured bones:_____

Have you been treated for any health conditions by a physician in the last year? Y____N____

Describe:_____

What medications or drugs are you taking?_____

Have you ever been under chiropractic care? Y_____ N_____

Doctors name:_____

Have you ever suffered from:

____ Allergy	____Poor Posture	____Tuberculosis	____Itching
____Dizziness	____Sciatica	____Bruise easy	____Varicose Vein
____Fatigue	____Spinal curves	____Hay fever	____Ankle Swelling
____Headache	____Swollen joints	____Nosebleeds	____Frequent Urination
____Loss of sleep	____Colon trouble	____Sinus infection	___Kidney infection/Stone
____Ulcers	____Diarrhea	____High blood pressure	____Prostate trouble
____Depression	____Digestion	____Low blood pressure	____Cramps/backache
____Numbness	____Hemorrhoids	____Pain over heart	____Cancer
____Arthritis	____Nausea	____Poor circulation	____Hot flashes
____Bursitis	____Asthma	____Irregular cycle	____Chest pain
____Foot trouble	____Colds	____Lumps in breast	____Failing vision
____Low back pain	____Deafness	____Anemia	____Alcoholism
____Neck pain	____Ear noises	____Stroke	____Diabetes
____Neck stiffness	____Enlarged thyroid	___Irregular heartbeat	

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

Do you: Now take vitamins or minerals? Y___ N____

Think you need vitamins or minerals? Y____ N_____

Are you wearing: ____Heel lifts ____Sole lifts ____Inner soles ____Arch supports

Family Health History:

____Diabetes ____Depression ____Heart disease ____Osteoporosis ____Digestive issues

____MS ____Stroke ____High blood pressure ____Arthritis ____Cancer

Other:_____

I hereby declare that the above statements are true and correct to the best of my knowledge.

Signature:_____ Date:_____

HILLCREST CHIROPRACTIC ASSOCIATES

Dr. Waring Johnston D.C.

Office Policies

Our fees are based on our knowledge, skill and service and you will find them consistent with the high quality of care you receive. Your charges will depend on the office visit,office test and type of care you receive in our office. We file insurance as a courtesy and you are responsible for any unpaid balances.

There will be an Exam Fee incurred if it has been more than a year since your last visit or at the doctors discretion.

All payments are due at the time of service. If this is a problem, please notify the front office staff prior to seeing the doctor. Also, If there has been a change in your insurance please notify front office staff. We Do Not Bill.

Medical information is only released with your written consent.

Due to limited office space and HIPPA regulation we request Patients Only in the exam room. Children and Elderly persons may be accompanied for assistance.

We require 24 HOUR NOTICE for cancellation or rescheduling as this time is reserved for you. A $35 fee will be incurred after the 2nd missed appointment.

Patient Signature:_____

Date:_____

Hillcrest Chiropractic Associates
Dr. Waring Johnston

Healthcare Authorization Form

Patients Name_____
Date Of Birth_____

The patient identified above authorizes Hillcrest Chiropractic Associates to use and or disclose protected health information in accordance with the following:

____I give permission to Hillcrest Chiropractic Associates to use my address,phone number and clinical records to contact me with appointment reminders and missed appointment notifications.

____If Hillcrest Chiropractic Associates contact me by phone, I give them permission to leave a message on my answering machine or voice mail.

____I give Hillcrest Chiropractic Associates permission to treat me in an open treatment room. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, a room will be provided for these conversations.

____By signing this form you are giving Hillcrest Chiropractic Associates permission to use and disclose your protected health information accordance with the directives listed above.

Right to Revoke Authorization

You have the right to Revoke this authorization in writing at any time. You may revoke this authorization with a written notice to Hillcrest Chiropractic Associates.

Patients Signature_____
Date_____