Ennis
Chiropractic Clinic
& Wellness Center

New Patient Intake Form

Patient Information

Name: _____ DOB: _____ SS #_____ Date _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Email: _____ Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____
How did you hear about our office? _____
Emergency Contact Name: _____ Relationship: _____ Telephone #:_____

Employment Information

Current Employment: ☐ Employed ☐ Unemployed ☐ Homemaker ☐ Student ☐ Minor ☐ Retired
Employer's Company Name: _____ Job Title: _____
Here for: ☐ Alignment ☐ Posture ☐ Athletic Performance ☐ Pain Relief

Presenting problem

What is the presenting problem/chief complaint? _____
When/How did this start? _____
Have you had this or similar conditions in the past? ☐ Yes ☐ No
Is this condition getting (circle): Worse Better Same Recurring
Is this pain (circle): Dull Achy Sharp Stabbing Electrical Throbbing Stiffness Cramps Other: _____
Rate pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)
Frequency: (Percentage of day symptoms felt) 0%-25% 26%-50% 51%-75% 76%-100%
Any (circle): Numbness / Tingling / Weakness / Changes in Bowel or Bladder habits / Headache / Nausea / Pain with Sneezing, Coughing, Straining / Dizziness / Fever / Fatigue Other: _____
How does this condition interfere with your daily routine? _____
What aggravates your condition? _____
What relieves your condition? _____
Types of previous treatment and/or surgery for this condition? _____

Personal Health History

Overall Stress Level: 0 1 2 3 4 5 6 7 8 9 10
Overall Health Level: 0 1 2 3 4 5 6 7 8 9 10
Medications, including over the counter, you currently take:

_____

_____

Allergies: _____
Vitamins/Supplements you currently take: _____
List any serious illness you have had: _____
Date of last physical examination: _____ Please list any abnormal findings: _____

_____

Surgeries: _____
Have you ever been diagnosed with cancer? ☐ Yes ☐No If yes, what kind? _____
Family Health History: describe any condition/diseases (i.e. heart disease, diabetes, and other inherited diseases) suffered by family members: _____

Patient Signature_____ Date_____

Ennis Chiropractic and Wellness Center ~ Dr. William Davis, DC
109 N.W. Main St. Ennis, Texas 75119 Ph:(972)875-9377 Fax: (972)875-4325 ennischiro2014@gmail.com

Motor Vehicle Collision Questionnaire

Name: _____ **Date:** _____ **Date of Accident:** _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type: Year_____ Make_____ Model_____

Your position in vehicle: ☐ Driver ☐ Passenger ☐ Rear left ☐ Rear right ☐ Rear middle

Speed of vehicle: _____ MPH ☐ Slowing ☐ Accelerating ☐ Stopped

Collison type: ☐ Driver side impact ☐ Passenger side impact ☐ Head on impact ☐ Rear End impact

Describe the accident in your own words: _____

_____

_____

_____

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type: Year_____ Make_____ Model_____

CONDITIONS AT TIME OF ACCIDENT

Road conditions: ☐ Dry ☐ Wet ☐ Snow covered

Time of Day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Visibility: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you: ☐ Unaware of impending accident ☐ Aware ☐ Braced for it ☐ Wearing seat belt

If you were the driver, was your foot on the brake pedal? ☐ Yes ☐ No

Was the airbag deployed? ☐ Yes ☐ No

Was your headrest: ☐ Lowered ☐ middle position ☐ highest position

Position of head at impact: ☐ Facing straight ahead ☐ Tilted forward ☐ Rotated right ☐ Rotated left

Position of body at impact: ☐ Facing straight ahead ☐ Tilted forward ☐ Rotated right ☐ Rotated Left

Damage to the vehicle you were in: ☐Minimal ☐ Moderate ☐Severe/Totaled

AS A RESULT OF THE FORCE OF THE COLLISON, WHICH OBJECTS DID YOUR BODY STRIKE?

Head: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Right arm: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Left Arm: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Right leg: ☐Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Left leg: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Body: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door ☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness? ☐ Yes ☐ No

Were you able to walk unaided? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No If yes, which one_____

Did you receive care from an ambulance? ☐ Yes ☐ No

Immediately following the accident, did you feel: ☐ Dizzy ☐Weak ☐ Dazed ☐ Nausea ☐ Disoriented

Next day discomfort? ☐ Increased ☐ Decreased ☐ Same

Did your major complaints exist BEFORE the accident? ☐Yes ☐ No

In what area did you IMMEDIATELY feel pain?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid Back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Lower back	☐ Pelvis					

Where did you experience pain on the days FOLLOWING the accident?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid Back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Lower back	☐ Pelvis					

Health Issues

☐ Numbness	☐ Nausea	☐ Shortness of Breath
☐ Paralysis	☐ Vomiting	☐ Irregular Heart Rate
☐ Dizziness	☐ Diarrhea	☐ Lung Problems
☐ Forgetfulness	☐ Constipation	☐ Varicose Veins
☐ Confusion	☐ Hemorrhoids	☐ Ankle Swelling
☐ Convulsions	☐ Gall Bladder Trouble	☐ Vision Problems
☐ Allergies	☐ Weight Gain/Loss	☐ Dental Problems
☐ Loss of Sleep	☐ Abdominal Pain	☐ Sore Throat
☐ Fever	☐ Heartburn	☐ Ear Aches
☐ Headaches	☐ Bladder trouble	☐ Hearing Difficulty
☐ Change in Appetite	☐ Discolored/Painful Urination	
☐ Excessive Thirst	☐ Chest Pain	☐ Other: _____

Automobile Insurance Information

Do you or someone else have insurance coverage for the vehicle you were in? ☐ Yes ☐ No
If someone else, please list their name: _____
How is this person related to you? ☐ Parent ☐ Friend ☐ Other: _____
Medical Benefits Coverage: ☐ Yes ☐ No Limit: ☐ $3,000 ☐ $5,000 ☐ $15,000 Other: _____
Date of Injury: _____ Location of Incident (City, State, Zip): _____
Automobile Insurance Carrier Name: _____
Auto Carrier Telephone #: _____ Driver's Claim #: _____
Do you have secondary insurance (Blue Cross, Aetna, etc.)? ☐ Yes ☐ No
Name of Secondary Insurance: _____ Policy # _____ Group # _____

Attorney

Do you have an attorney representing you? ☐ Yes ☐ No ☐ Not yet
Attorney Name: _____ Telephone #: _____ Fax: _____
Have you had any other exam/treatment provided for your injuries prior to our office? ☐ Yes ☐ No

I authorize payment to be made directly to Ennis Chiropractic and Wellness Center. The above-named doctor may use my healthcare information and may disclose such information to the above-named attorney or third parties 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 treatment plan is completed or one year from the dated signed below.

Patient's Signature: _____ Date: _____

HIPPA Notice of Privacy Practices at Ennis Chiropractic and Wellness Center

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

In the course of your care as a patient at Ennis Chiropractic and Wellness Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of you clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest of you.

In effective, we do send text messages to remind you of your appointment, or may leave a message on your answering machine or voicemail due to certain circumstances. Further, you have the right to inspect or obtain a copy of the information we use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care we provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint to: Front office.

If you would like further information about our privacy policies and practices please feel free to contact us at (972)875-9377.

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matter related in an "open-door" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Ennis Chiropractic and Wellness Center or on your relation with our staff.

This notice is effective as of January 1, 2015. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (printed)	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____	_____
Personal Representative (printed)	Personal Representative (Signature)	Date

_____

Description of the authority to act on behalf of the patient

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Ennis Chiropractic & Wellness Center, PA, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concering my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim(s) for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Ennis Chiropractic & Wellness Center, PA, 109 NW Main St, Ennis, Texas 75119.

THIRD PARTY LIABILIY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Ennis Chiropractic & Wellness Center, PA, 109 NW Main St, Ennis, Texas 75119.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/clinic named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance companies requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Patient Name _____ Responsible Party Signature _____ Date _____

Ennis Chiropractic & Wellness Center, P.A.

Dr. William C. Davis, D.C., D.A.A.C.A, C.D.T.P

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Ennis Chiropractic Clinic reserves the right to charge a fee of $25.00 for all missed appointments ("NO SHOWS") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice.

"NO SHOW" fees will be billed to the patient. The fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "NO SHOWS" in an 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Ennis
Chiropractic Clinic
& Wellness Center

109 NW Main St., Ennis, Texas 75119
Ph. (972)875-9377 Fax: (972)875-4325