Patient's Name _____

CASE HISTORY

Please circle the category that best describes your past/present health

HISTORY (Including Childhood Illnesses)

Allergies	Bronchitis	Diabetes	Gonorrhea	Kidney Issues	Mental Illness	Rheumatic Fever	Tuberculosis
Alcoholism	Cancer/Tumors	Diphtheria	Heart Issues	Liver Issues	Mumps	Scarlet Fever	Typhoid Fever
Anemia	Chicken Pox	Epilepsy	Hepatitis	Malaria	Pneumonia	Syphilis	Thyroid Issues
Arthritis	Dental Problems	Gall Bladder	Influenza	Measles	Polio	Tonsillitis	Ulcers

FAMILY HISTORY (Only Close Relatives)

Arthritis	Diabetes	Heart Disease	Kidney Disease	Thyroid Problems	Other_____
Cancer/Tumor	Glaucoma	High Blood Pressure	Low Blood Pressure	Tuberculosis	

SYMPTOMS

MUSCULOSKELETAL

Arm/Leg Problems	Feet/Hand Problems	Neck Pain	Painful Breathing	Swollen/Painful Joints
Back Pain	Hernia	Neck Stiffness	Spinal/Head Injuries	Upper Back Pain

NEUROMUSCULAR

Cold Hands/Feet	Ears Ring	Headache	Loss of Memory	Paralysis	Tension
Cold Sweats	Fainting Spells	Irritability	Loss of Smell/Taste	Pins/Needles in Arms/Legs	Tremors
Depression	Fatigue	Light Bothers Eyes	Nervousness	Seizures	
Dizziness	Fever	Loss of Balance	Numbness in Fingers/Toes	Sleeping Issues	

DIGESTIVE

Abnormal Stool	Blood in Urine	Excessive Gas	Excessive Urination	Nausea	Pus in Urine
Bed Wetting	Constipation	Excessive Hunger	Hemorrhoids	Pain Over Stomach	Vomiting
Blood in Stool	Diarrhea	Excessive Thirst	Loss of Bladder Control	Poor Appetite	Weight Gain/Loss

GENERAL

Asthma	Coughing up Phlegm	Hearing Impairment	Postnasal Drip	Sinusitis	Varicose Veins
Chest Pain	Ear Discharge	Hoarseness	Rapid Heart Beat	Skin Problems	Vision
Chronic Cough	Eyestrain	Nosebleeds	Shortness of Breath	Sore Throat	

HABITS

Alcohol	Coffee	Narcotics	Stimulants	Tranquilizers	Other _____
Aspirin	Laxatives	Sleeping Pills	Tobacco	Vitamin/Mineral Supplements	

MALE

Painful Urination Prostate Problems

FEMALE/REPRODUCTIVE

Birth Control Pills	Chronic Fatigue	Hysterectomy	Lumps on Breasts	Painful Urination	No. Successful Pregnancies ____
Breast Soreness	Heavy Bleeding	Irregular Flow	Menopausal Issues	PMS	No. Miscarriages/Abortions____

COMMENTS:

CA

BOLZ CHIROPRACTIC CLINIC
4990 SW 21ST STREET
TOPEKA, KS 66604

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program this form must be fully completed

First Name:_____ Last Name:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

ASSIGNMENT, AUTHORIZATION AND LIEN

Re: Payment to **Bolz Chiropractic Clinic** for services rendered to:

_____

I hereby authorize and direct you, my attorney, and/or Insurance company to pay directly to **Bolz Chiropractic Clinic** such sums as may be due and owing for professional services rendered to me by reason of this accident or illness, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Bolz Chiropractic Clinic against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries or illness for which I have been treated.

I fully understand that I am directly responsible to the above assignee for all medical bills submitted by them for services rendered to me. I understand and agree that this assignment, lien and authorization do not constitute any consideration for the office to await payment and they may demand payments from me immediately upon rendering services at their option. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. I authorize the previously mentioned Doctors to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above office be given power of attorney to endorse/sign my name on any and all checks for payment and any indebtedness owed to the previously mentioned Doctors and assignee.

A photocopy of this agreement, authorization and lien shall be considered as effective and valid as the original.

PATIENT'S SIGNATURE _____ & Date_____

The following is required prior to your receipt of a narrative report and itemized billing:

PATIENT'S INSURANCE CO: _____

ADDRESS & PHONE NO: _____

ADJUSTER: _____CLAIM or FILE NO: _____

The undersigned being attorney of record for this patient does hereby agree to observe all the terms of the above and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect **Bolz Chiropractic Clinic.**

ATTORNEY'S SIGNATURE: Date: _____

LN

INSURANCE POLICY

Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered" or "denied". We will file your insurance claim as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. By signing this lien, you are authorizing your insurance company to assign payment directly to our office.

Date _____ Signature _____

X-RAY POLICY

In the event it is necessary for the doctor to take x-rays, the following policy will apply.

X-rays taken in the office are the responsibility and property of **Bolz Chiropractic Clinic** and are permanent records. If it is necessary to send your x-rays elsewhere, these can be mailed at the request of another licensed health care practitioner after authorization has been received in writing.

Date _____ Signature _____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize _____

To administer treatment as they so deem necessary to my

_____

Signed _____

Date _____

Witness _____

Effective Date: April 14, 2003

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Timothy D. Bolz, DC as Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)

(Notation, if any, by staff)

This form will be retained in you health record.

HIPPA