Mount Joy Chiropractic

Optimal Spine = Optimal Health

Donald P. Henriques, JR, D.C.
1013 W. Main Street, Suite 1, Mount Joy, PA 17552
Phone: (717)367-6224 Fax: (717) 441-8415

Name: _____ **Primary Tele #:** _____

Secondary Tele #: _____ **Email:** _____

Address: _____ **City/State/Zip:** _____

DOB: _____/_____/_____ **SSN:** _____

Marital Status/Spouse Name: _____ **Children:** _____

Emergency Contact Person & Tele #: _____

Occupation: _____ **Employer:** _____

Insurance Co: _____ **Member ID #:** _____

1. Most of our patients are referred by a caring friend, family member or doctor. We really appreciate referrals. Who encouraged you to visit our office? _____

2. Research shows that your spine should be checked regularly. How many times have you been adjusted in your lifetime & when was your last adjustment? _____

3. When was your last complete Spinal Exam including X-rays? _____

4. Have you ever been told that you have a spinal curvature or spinal arthritis? **Yes** **No**

5. Unhealthy spines cause decay which eventually results in cracking or grinding. Do you ever hear noises or feel grinding when you move your neck or lower back? _____

6. Do you have difficulty turning your head to back up a car or to see traffic while merging onto a highway?
Yes **No**

7. Poor posture leads to poor health and often indicates spinal problems. How would you rate your overall posture?
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress levels: **Low Medium High**

9. During pregnancy the stresses on your spine and pelvis are increased significantly. Is there any chance that you are pregnant? **Yes** **No**

10. When was your last car accident or work injury? _____

By signing below, I certify to the best of my knowledge that the above information is complete and accurate.

Patient Signature: _____ Date: _____

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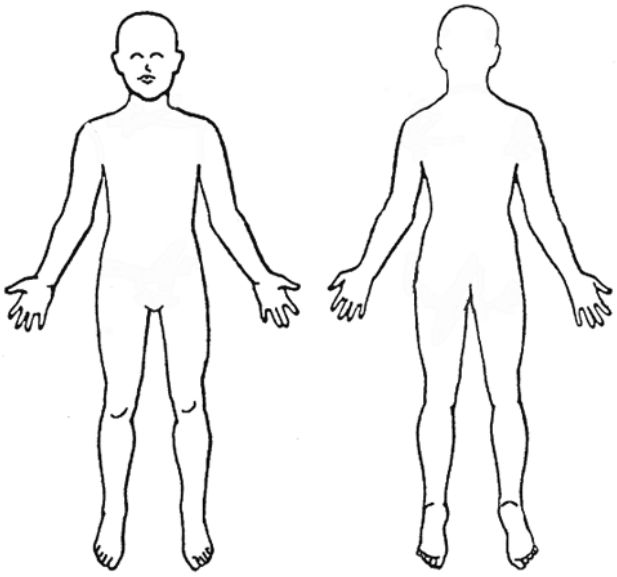
Current Health Problem(s)

Patient Name: _____ Date: _____

Please specify below the area(s) where you are experiencing pain, discomfort or other symptoms:



When/how did the current problem(s) begin?

_____

_____

_____

Where do you picture yourself in 1-2 years if this problem isn't taken care of?

_____

What do you most desire from receiving treatment with us?

_____

Please list any surgeries you have had &/or medications that you are currently taking:

_____

_____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ acknowledge that Mount Joy Chiropractic's Notice of Privacy Practices has been provided to me.

I understand I have a right to review Mount Joy Chiropractic's Privacy Notice prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of for Mount Joy Chiropractic.

The Notice of Privacy Practices for Mount Joy Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights for Mount Joy Chiropractic's duties with respect to my protected health information.
Mount Joy Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or by accessing Mount Joy Chiropractic's website (if applicable).

I have the right to revoke this consent, in writing, except to the extent that Mount Joy Chiropractic has taken action in reliance on this consent.

Patient Acknowledgment

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

X _____
Signature of Patient/Parent or Guardian

Print _____ Date _____
Name of Patient/Parent or Guardian

Request for Payment of Benefits to Provider of Care

I hereby authorize my insurance company/insurance administrator to be billed and render payment directly to Mount Joy Chiropractic for expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I also acknowledge that I may be held responsible for any services not covered by my insurance policy.

Patient's Signature: _____ Date _____