APPLEWOOD CHIROPRACTIC
Robert Donald Jackson, Jr. P.C.

Robert D. Jackson, D.C.
12505 W. 32nd Avenue ~ Wheat Ridge, Co 80033
(303) 237-9617 ~ Fax (303) 237-6253

Date: _____ Staff Name: _____

Confidential Patient Information

Name: _____ Race & Ethnicity: _____ Decline: ____
Multi-Racial: _____ Yes _____ No _____ Unknown

Chief Complaint(s): _____ Referred By (Dr.?) _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Social Security #: _____ Email: _____

Date of Birth: _____ Age: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Ins. Company: _____ ID #_____ Group: #_____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Person to contact in case of emergency (Name and Phone): _____

What operations have you had? _____

_____ When? _____

Serious Illness: _____ When? _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Applewood Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such provider and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named Provider and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and clinic in any attempts by such provider and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, to bring suit with such provider and clinic against such insurers and/or employee health care plan in my name but at such provider and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

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Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Applewood Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

(Women ONLY) (ALL PATIENTS)

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages regarding your personal healthcare information on any answering device?
i.e. home answering machines , voicemails, email or text messaging ? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Name: _____ **DOB:** _____
Email: _____

Medications:

Medication Name	Dose	Times Taken	How Long

Allergies:

_____

_____

Smoking History:

- Do you smoke? **Yes or No**
  If **Yes** for how long? _____ How many packs per day? _____
  If **No** did you used to smoke? **Yes or No**
  If **Yes** when did you quit? _____

OFFICE USE ONLY

Vital Signs:

Height: _____ **Weight:** _____ **BMI:** _____

BP: _____ **HR:** _____ BPM **SaO_2:** _____ %