ACE Family Chiropractic

14311 Reese Blvd. West, #A1
Huntersville, NC 28078
704-727-0784 • 888-758-9829 (FAX)
info@AceFamilyChiropractic.com

Patient Entrance Data

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health issues and deliver the best possible treatment.

First Name		Last Name	
Address		Birthdate	Sex ☐M ☐F
City		State	Zip
Home / Cell Phone		Work Phone	
Insurance		E-mail	
Policy Holder's Name		May we E-mail you?	☐Yes ☐No
Subscriber ID		Marital Status	☐S ☐M ☐D ☐W ☐Other
Group #		Employer	
Emergency Contact		Occupation	
Relationship		Emergency Phone	

If you are not the Primary Insurance Policy Holder, please provide his or her information below:

First & Last Name	Soc. Sec. #	DOB	What is your relationship?

Address	City	State	Zip

Personal Health History

	Yes	No	If yes, explain briefly
Are you pregnant?	☐	☐	
Do you smoke?	☐	☐	
Have you ever. . .			
. . . had cancer?	☐	☐	
. . . had a surgery?	☐	☐	
. . . had a broken bone?	☐	☐	
. . .been in a car accident?	☐	☐	

Family Health History

List any health conditions that a blood relative may have (i.e. Cancer, Diabetes, Epilepsy, Stroke)

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How did you hear about us? _____

What brought you in today? _____

When did your symptoms begin? _____

What do you think was the cause? _____

Are your symptoms changing? ☐ Getting Better ☐Not Changing ☐Getting Worse

What makes it better? _____

What makes it worse? _____

Frequency of symptoms? _____

How long does each episode last? _____

Rate the severity of your symptoms from 1 – 10 (10 being the worst) _____

Do these symptoms interfere with your ☐ work ☐ sleep ☐ other _____

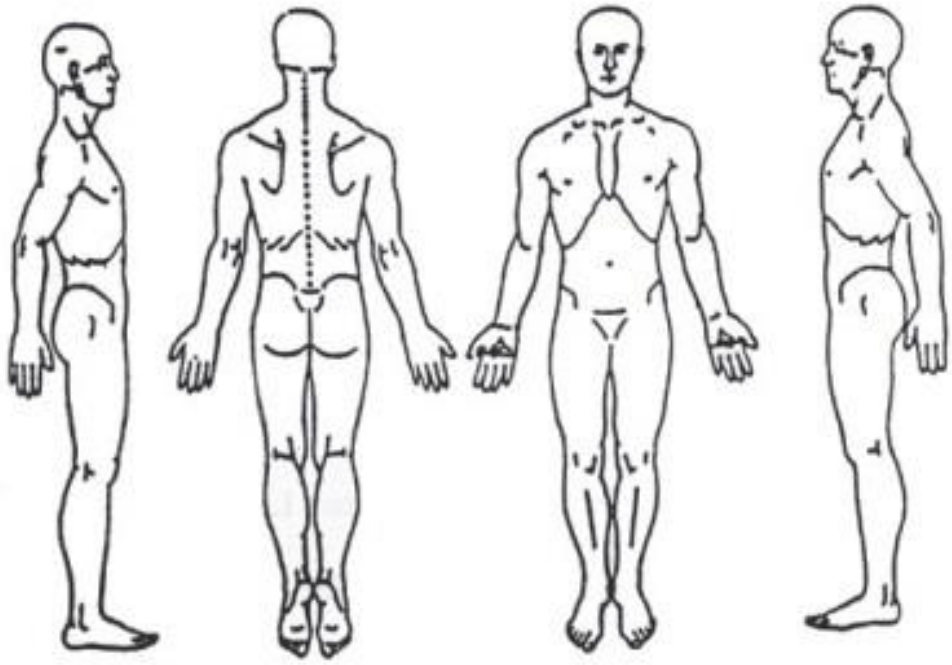
Have you consulted a healthcare professional about these symptoms? _____

If yes, who and what was the diagnosis? _____

_____

_____

Please "X" on the area(s) where you have discomfort and draw lines to where it radiates.



Describe your symptoms (i.e. sharp, dull numbing, shooting, burning, tingling, stabbing, radiating, etc.)

_____

_____

_____

_____

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List any other conditions you may have or health concerns that our staff should be made aware of:

List any medication you are currently taking and why:

Last chiropractor seen _____
Date of last visit _____
Reason for visit _____

Last medical doctor seen _____
Date of last visit _____
Reason for visit _____

Thank you for completing this intake form. Information contained within this form is confidential and your honest responses are critical to helping us deliver the best possible treatment.

Patient Signature _____ Print Patient Name _____ Date _____

CONSENT TO TREAT A MINOR

I hereby request and authorize Dr. Teng Xiong and whomever he may designate as his assistant or authorized representative to administer chiropractic care as he deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

As of today's date, I have the legal right to select and authorize healthcare service for the minor child named below. I will notify this office in writing immediately should I wish to terminate this consent.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Child's Name _____ Your Relationship to Child _____

Parent / Guardian Signature _____ Print Parent / Guardian Name _____ Date _____

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CONSENT OF TREATMENT

Healthcare providers are required to advise patients of the nature of treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective in the treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. ***Musculoskeletal care contributes to your overall wellbeing. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address and nature of the treatment.
b. The risks and benefits of that treatment.
c. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Ace Family Chiropractic.

_____	_____	_____
Signature (Patient / Guardian)	Print Name	Date

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Consent for Purposes of Treatment, Payment, & Healthcare Operations

I understand and have been provided with a copy of Ace Family Chiropractic's Notice of Privacy Practices, which provides a more complete description on the uses and disclosure of my health history. I understand that I have the right to review the notice prior to signing this consent. I understand that Ace Family Chiropractic has the right to change this notice of practice prior to implementation and will mail a copy of any revised notice to the address I've provided.

By signing below I give my consent for Ace Family Chiropractic to disclose my record for treatment, payment, and healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that Ace Family Chiropractic has already taken action in reliance thereon.

I provide Ace Family Chiropractic with my authorization and consent to use my protected healthcare information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

_____	_____	_____
Signature (Patient / Guardian)	Print Name	Date

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NOTICE OF PRIVACY PRACTICES

ACE Family Chiropractic is required by law and in compliance with HIPPA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

There are a number of situation in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and healthcare operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or healthcare operations requires you to sign an Authorization.

You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to such restrictions. Certain disclosures required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so.

Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

As a courtesy, we may call your home or leave a message, stating your next appointment date and time or missed appointments. We may call your work and leave a message to return our call. No personal health information will be disclosed.