Martin Chiropractic Center

Personal Confidential History

Date:		
PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Address:		City, State ZIP
Home Phone:	Work Phone: ( )	Cell Phone: ( )
Date of Birth: / /	Age:	Number of Children:
SSN No.:	Spouse:	
How did you hear about us?		
Employed by:		Occupation:
Are you a student? Yes / No	If so, are you: Full Time / Part Time	
Family Physician:	Dentist:	
Previous Chiropractic Care? Yes / No	If yes, with whom?	
Location of pain or reason for visit:		
Date of onset: / /	Accident related? Yes / No	If yes, please describe:
Date of Injury: / /	Treatment Received:	
What medications are you taking:		
What vitamins are you taking:		
Serious illness or family illnesses?:		
List any surgeries you have had:		
What do you hope to do better or enjoy more when you regain your health?:		
Rate your overall health	Excellent • Good • Fair • Poor	
Energy level is generally	Excellent • Good • Fair • Poor	
My quality of sleep is	Excellent • Good • Fair • Poor	
I go to the dentist	Regularly • Occasionally • Emergency	
Have you had x-rays taken on the area that is hurting?		
If yes, where were they taken?		
INSURANCE INFORMATION		
Do you have insurance? Yes / No	Name of carrier:	
Insured's name:	Relationship:	
Patient/Guardian Signature		

Martin Chiropractic Center
2756 Veach Rd
Owensboro, KY 42303

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270-688-0234

Your insurance is an agreement between you and your insurance carrier. As a courtesy to our patients, we will submit your claim for you, however, you are responsible for payment of services.

Primary Insurance	Secondary Insurance
Member Name	Member Name
ID# of Insured	ID# of Insured
Member's Birth Date	Member's Birth Date

Please Circle One:

#1 **CASH** - payment expected on day of service.
#2 **INSURANCE** - patient to pay insurance co-pay or deductible on date of service.
#3 **MEDICARE** - patient to pay what medicare does not pay.
#4 **INDUSTRIAL, INJURY (WORK COMP)** - will be filed with your employer.
#5 **PERSONAL INJURY** - claims will be filed after verification with ins. company.
#6 **MEDICAID** - insurance will be filed.
#7 **SPECIAL ARRANGEMENTS** - if arrangements are necessary, please notify our receptionist before services are rendered.

I authorize and request payment of medical benefits be paid directly to my physician. If insurance denies payment, I agree to be personally and fully responsible for payment of services not covered by insurance.

I give permission for this office to receive any medical reports, x-rays, or anything necessary to aid in my treatment.

I authorize the release of any medical information necessary to process my insurance claims and obtain reimbursement.

Permission for treatment is granted for such medical treatment deemed necessary.

Patient's Signature:	Date:
Parent or Guardian:	Date:

Eric L. Martin, B.A., D.C.
Martin Chiropractic Center
2756 Veach Rd.
Owensboro, KY 42303

PATIENT ACKNOWLEDGEMENT OF PRIVACY NOTICE

(to be maintained with Patient's chart)

I HAVE BEEN TOLD ABOUT THE PRIVACY FORM AND IT IS LISTED IN THE WAITING ROOM. I MAY READ IT OR ASK TO TAKE ONE HOME IF I NEED TO.

This is to acknowledge that I have been given the opportunity to review the **Notice of Privacy Practice** for the practice of Dr. Eric Martin: Martin Chiropractic Center located at 2756 Veach Road, Owensboro, KY 42303. I understand that I have the right to request a personal copy of this office's Notice of Privacy Practices, and that I have the right to complain to the Secretary of Health and Human Services or to the Privacy contact, Lynda Foster, at this office if I believe that my privacy rights have been violated.

Patient Name (please print):	Witness:
Patient Signature *(or signature of legal representative Parent, if minor or guardian):* X	Date:

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI to be made by the alternative mean, such as sending correspondence to the individual's office instead of the individual's home. This office will honor all such reasonable requests.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Prefered Method	**Description / method of contact (please provide numbers / addresses, etc.)**
____ Yes ____ No	Telephone:
____ Yes ____ No	Office phone:
____ Yes ____ No	Home Address:
____ Yes ____ No	Business Address:
____ Yes ____ No	Other (must complete if all above = no):

Note: These instructions will stay in effect until you notify us otherwise