Chiropractic Wellness Center, LLC
300 S. Rodney Parham, Ste 11
Little Rock, AR 72205-4747

PATIENT INFORMATION

Date________________

Patient____________________________________ Sex:____M____F Age_________
Address________________________________Apt.______ Birthdate_________
City____ State____________ Zip_________
Single______Married______Widowed______Separated______Divorced______
Patient SS#__________________________ Occupation_____________________
Employer____
Employer Address____
Spouse's Name_________________________ Occupation_____________________
Birthdate__________________________ SS#__________________________
Spouse's Employer____
Referred By:____

PHONE NUMBERS

Home___________________ Work_________________ext__________ Cell___________
Best time and place to reach you____
Email Address____
Preferred method of contact: Phone _____ Email_____ Text______ Fax ______Mail______
IN CASE OF EMERGENCY, CONTACT
Name__________________________________ Relationship_______________________
Home Phone______________________________ Work Phone_______________________

INSURANCE

Who is responsible for this account? ____
Relationship to Patient___________________________
Insurance Co.________________________________ Group #_______________________
Is patient covered by additional insurance? ______________ ________Yes_______No
Subscriber's Name (for secondary insurance) ____________________________________
Birthdate __________________________ SS#______________________
Relationship to Patient___________________________
Insurance Co.________________________________ Group #____________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent)have insurance coverage with______________________ and assign directly to Dr. Trudy L. Bennett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

___________________________________ ___________________________________
Relationship Date

(over)

PATIENT CONDITION

Reason for visit? ____

When did your symptoms appear? ____

Is this condition getting progressively worse? _______Yes ________No _________Unknown

Rate the severity of your pain on a scale of 1(least pain) to 10(severe pain)______________________

Type of pain: ____Sharp ____Dull ____Throbbing ____Numbness _____Aching
____ Shooting _____Burning ____Tingling ____Stiffness _____Swelling
____Other ____

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with ____Work ____Sleep ____Daily Routine ____Recreation

What activities or movements are difficult to perform?____

Was this condition due to an accident? ____Yes ____No

If yes, Date of Accident____

Type of Accident____

Do you have an attorney? ____Yes ____No Name:______________________________

HEALTH HISTORY

What treatment have you received for this condition?____

Other doctors seen for this condition____

Date of Last: Spinal X-Ray________________________

Spinal Exam____________________ MRI, CT, Bone Scan____________________

List any other conditions that we should be made aware of regarding you health.

____

____

____

Have you seen a chiropractor before? _____Yes(last treatment)________________________ _____No

If yes, did your last chiropractor create a schedule of spinal maintenance for optimum spinal function?

_____Yes _____No If yes what was that schedule? ______________________________

What are your goals for care (mark all that apply) _____Temporary Pain Relief

_____ Maximum Chiropractic Improvement _____Wellness/health

_____Other____

Chiropractic Wellness Center, LLC

Trudy Bennett, D.C.
Antoine De Ras, D.C.

300 South Rodney Parham Road, Suite 11
Little Rock, AR 72205-4774
(501) 663-4663

Patient Privacy Act

May we have your permission for the following:

1. **May we leave messages regarding appointments on your voicemail (answering machine)?**

   At Home Yes No

   On Cell Yes No

   At Work Yes No

2. **May we leave a message with anyone who answers your phone?** Yes No

Name of designated individuals	Relationship to you

3. **Do you want anyone to have access to your records?** Yes No

Name of designated individuals	Relationship to you	Phone Number

I ______________________ have given Chiropractic Wellness Center, L.L.C. my answers on how I want my privacy to be protected.

______________________________ ______________

Patient's (Legal Guardian's) Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ **Patient ID #:** ____________________

I hereby acknowledge that I have received a copy of Chiropractic Wellness Center L.L.C.'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

____________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____

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Trudy L. Bennett, DC

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____________________ ____________________ __________

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child:

I ____________________ being the parent or legal guardian of ________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________________

____________________________ __________

Signature **Date**