Moeckel Chiropractic Physicians

Patient Update Form

For Office Use Only

Date: _____

Acct #:_____

Name: _____ Phone #_____

Address_____Occupation_____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: _____

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _____

Briefly describe your pain or trouble and what caused it:_____

_____

_____

List symptoms experiencing today: Choose the severity level associated with each symptom

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Since your last visit, with us, have you seen any other Doctor?❑Yes ❑No If so, whom?_____

Diagnosis by above listed Doctor?_____

❑Tests/Studies: _____

❑Medications: _____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc?❑Yes ❑No If yes, which ones?: _____

Do you have allergies? ❑Yes ❑No If yes, please explain: _____

Have you any surgeries since last visit? ❑Yes ❑No Type and date:_____

Last adjustment:_____ Last Physical:_____

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Personal Medical Information Consent

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. You have the right to revoke, in writing, this consent form at any time, although any services preformed prior to the revocation of this consent are covered by this consent. HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions, but if we do they are legally binding. You have the right to revoke, in writing, this consent form at any time, although any services preformed prior to revocation of this consent are covered by this consent. Restrictions:

Patient's/Guardian's Signature: _____ **Date:** _____

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices, These changes in our office's polices and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor's/Staff's Signature: _____ **Date:** _____