

PATIENT INFORMATION

Name : \_\_\_\_\_ Date: \_\_\_\_\_  
(Last Name, First Name, MI) Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Sex: Male Female Marital Status: Married Single Divorced Widowed Other

Employed: Full Time Part Time Unemployed Student Full Time Other

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name (If under 18 years of age): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ Company: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ Company: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

INSURANCE AUTHORIZATION AND RELEASE

I certify that the above information is correct to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between me and my insurance company. I authorize Carolina Chiropractic Clinic, PC/Dr. Kirstin Counts Prinkey to act as my agent in helping me obtain payment from my insurance company, and I authorize the release of any medical information pertinent to my treatment plan to my insurance company. **I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO ME DIRECTLY AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

I authorize my insurance company to make payment directly to Carolina Chiropractic Clinic, PC/Dr. Kirstin Counts Prinkey of the benefits allowable and otherwise payable under my policy as payment toward the total charges for professional services rendered. I agree to pay any balance of applicable charges on my account as outlined in my policy agreement (including copays, deductibles, coinsurance, or non-covered services).

I authorize the use of this form for all of my insurance submissions and permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE (Parent or guardian if under 18) PRINTED NAME DATE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### RELEASE OF MEDICAL RECORDS

I hereby authorize and instruct the release of all information and/or records concerning treatment and/or involvement in the care of my health to Carolina Chiropractic Clinic, PC/Dr. Kirstin Counts Prinkey, 221 NC Highway 42 E, Clayton, NC 27527. This information may include but is not limited to examination findings, treatment history, radiology and diagnostic test copies and/or reports.

### ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Carolina Chiropractic Clinic, PA privacy policies and I fully understand and agree to each item listed. In addition to the written policy notice, I agree to the following office practices and do not object:

- Patient names and first initials may appear on boards at the front desk to welcome them or to thank them for referrals.
- Patient first names may be called over a computerized calling system.
- Postcards may be sent to wish you a happy birthday, welcome you to the practice, to remind you of an appointment or to notify you of events occurring in the office.
- Health articles, newsletter and other office information may be sent to your home.
- Messages may be left on voicemail, an answering machine or with a family member.
- Should you share a written testimonial with us, we may display it in binders or use it in our advertising.
- Chiropractic adjustments are performed in an open adjusting area separated by a half wall.

\_\_\_\_\_  
SIGNATURE (Parent or Guardian if under 18)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's visit:    New Injury    Old Injury    Chronic Pain    Wellness

Please describe your condition or symptoms \_\_\_\_\_

Is your injury related to a work injury?    Yes    No    An auto accident?    Yes    No  
Have you received Chiropractic Care in the past ?    Yes    No    Date of Last Adjustment: \_\_\_\_\_

Please check any of the following conditions or diseases that you have or have had in the past:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Dizziness or Fainting   | <input type="checkbox"/> Headache           | <input type="checkbox"/> Postural Imbalance   | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Short leg/Orthotics     | <input type="checkbox"/> Ear Infection      | <input type="checkbox"/> Intestinal Problems  | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Frequent Colds          | <input type="checkbox"/> Sinus Problems     | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Bladder Problems     |
| <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> PMS                | <input type="checkbox"/> Menopausal Symptoms  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Venereal Disease   | <input type="checkbox"/> Shingles             | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> HIV/Aids           | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Ulcers/Colitis     | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Joint Replacement    |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Hyper/Hypothyroidism |
| <input type="checkbox"/> Frequent Neck pain      | <input type="checkbox"/> Disc Herniations   | <input type="checkbox"/> Low Back Problems    |   |

Other Medical Conditions: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Surgeries/Dates: \_\_\_\_\_

All Prescription and Over-the-Counter Medications: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you exercise?    Yes    No    If yes, how often \_\_\_\_\_

Do you smoke/use tobacco products?    Yes    No

Please list all vitamins and supplements you currently use: \_\_\_\_\_

Please mark any of the following emotional/chemical/physical stresses that you have experienced:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Slips/Fall                 | <input type="checkbox"/> Car Accidents            | <input type="checkbox"/> Sports Injuries   | <input type="checkbox"/> Physical Abuse            |
| <input type="checkbox"/> Poor Posture               | <input type="checkbox"/> Work Injuries            | <input type="checkbox"/> Sitting on Wallet | <input type="checkbox"/> Sleeping on Stomach       |
| <input type="checkbox"/> Computer Work              | <input type="checkbox"/> Extensive Driving        | <input type="checkbox"/> Prolonged Sitting | <input type="checkbox"/> Prolonged Standing        |
| <input type="checkbox"/> Repetitive Lifting/Bending | <input type="checkbox"/> Career Stress            | <input type="checkbox"/> Children Stress   | <input type="checkbox"/> Relationship Stress       |
| <input type="checkbox"/> Concealed Feelings         | <input type="checkbox"/> Quick Tempered           | <input type="checkbox"/> Caffeine          | <input type="checkbox"/> Poor Diet/Excessive Sugar |
| <input type="checkbox"/> Artificial Sweeteners      | <input type="checkbox"/> Smoker/Second Hand Smoke |  |  |

I certify that the above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian if under 18)