Reservoir of HEALTH 203-929-5700

Welcome

Patient Information (Please print)

First Name_____ MI_____ Last Name_____

Address_____ City_____ State___ Zip_____

S.S._____ Gender ☐ Female ☐ Male Birth date_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Spouse_____

Occupation_____ Employer_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

E-mail address_____

Person to contact in case of emergency_____ Relationship to patient_____

Emergency contact phone number(s)_____

Whom may we thank for referring you?_____

Responsible Party & Insurance Information

Name of person responsible for this account _____Relationship to patient _____

Insurance Co._____ PolicyID#_____ Group# _____

Subscriber/Guarantor's Name _____ Relationship to patient _____

Birth date_____ S/S #_____ Contact ph:_____

Name of employer_____ Contact ph:_____

Do you have additional insurance? ☐ Yes ☐ No If YES, please complete the following:

Insurance Co._____ PolicyID#_____ Group# _____

Subscriber/Guarantor's Name _____ Relationship to patient _____

Birth date_____ S/S #_____ Contact ph:_____

Name of employer_____ Contact ph:_____

Patient Condition

Is condition due to an accident or injury? ☐ Yes ☐ No If yes please fill out additional forms.

Reason for visit_____

When did you first notice symptoms?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of pain (1 mild or discomfort to 10 severe):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Type of pain:

☐ Sharp	☐ Throbbing	☐ Aching	☐ Shooting
☐ Burning	☐ Stiffness	☐ Dull	☐ Numbness
☐ Cramps	☐Swelling	☐ Tingling	☐ Other _____

How often do you have this pain?_____

Is the pain constant or does come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine

What is difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

☐ Other_____

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Patient name_____ DOB_____

Health History

What treatment have you already received? ☐ Medication ☐ Surgery
☐ Physical therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:_____

_____

Check to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Liver Disease	☐ Psychiatric Care
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Rheumatoid Arthritis
☐ Allergy Shots	☐ Epilepsy	☐ Migraine/Headaches	☐ Rheumatic Fever
☐ Anemia	☐ Fractures	☐ Miscarriage	☐ Scarlet Fever
☐ Anorexia	☐ Glaucoma	☐ Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Goiter	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Arthritis	☐ Gonorrhea	☐ Mumps	☐ Thyroid Problems
☐ Asthma	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Bleeding Disorders	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Breast Lump	☐ Hepatitis	☐ Parkinson's Disease	☐ Tumors Growths
☐ Bronchitis	☐ Hernia	☐ Pinched Nerve	☐ Typhoid Fever
☐ Bulimia	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Herpes	☐ Polio	☐ Vaginal Infections
☐ Cataracts	☐ High Cholesterol	☐ Prostate Problem	☐ Venereal Disease
☐ Chicken Pox	☐ Kidney Disease	☐ Prosthesis	☐ Whooping Cough
☐ Chemical Dependency		☐ Other:_____	

Dates of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Injuries/Surgeries you have had:	Description:	Date:
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Please list all medications you are currently taking: _____

_____

Please list all allergies_____

Please list all vitamins/herbs/minerals you are currently taking:_____

_____

Daily Habits

Type of exercise you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy Labor

Habits: ☐ Smoking Packs/day _____
☐ Alcohol Drinks/week _____
☐ Coffee/ Caffeine Drinks Cups/day_____
☐ High Stress Level Reason_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I am requesting treatment from Reservoir of Health, LLC for chiropractic adjustments and therapies. I understand that I may further request clarification about above mentioned therapies from my chiropractor. I authorize the chiropractor to release my information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment of co-pays for office fee is due the day of service. I understand that I will be charged a $50 fee for any cancellation with less than 24 hours advance notice. This fee is not covered by insurance.

X_____ _____
Signature of Patient/ Guardian Date

_____ _____
Printed Name Relationship to patient

Privacy Notice

Please read the first page of our privacy notice before reading and signing this.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health relation information should be proved to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Maura C. Lyddy, D.C.

If you would like further information about our privacy policies and practices, please contact Maura C. Lyddy, D.C.

X_____ _____
Signature of Patient/ Guardian Date

_____ _____
Printed Name Relationship to patient