

SOUTHWESTERN CHIROPRACTIC CENTER
801 North State Street, Clairton, PA 15025
Phone: 412-233-3600 Fax: 412-233-3702

Date _____
Acct# _____
X-ray # _____

Patient Entrance Form

Please Note: Our new extensive entrance form is necessary for compliance with the Health Care Financing Administration and the National Committee for Quality Assurance's new standards. Please fill it out completely.

Name _____ Phone () _____ Social Security # _____

Address _____ City _____ State _____ Zipcode _____

Age ____ Birthdate ____/____/____ Gender: M / F No. Children _____ Cell Phone () _____

Marital Status: Single Married Widowed Separated Divorced Student

Occupation _____ Employer _____ Work Phone () _____

Employer Address _____ City _____ State _____ Zipcode _____

Spouse Name _____ Social Security # _____

Occupation _____ Employer _____ Work Phone () _____

Emergency Contact _____ Phone () _____ Relationship _____

Patient's Primary Care Physician (PCP) _____ Phone () _____

Date of Last Physical Exam _____ Referred by: _____

Please describe your current problem _____

Is your current problem the result of: Auto Accident? Yes No Work Accident? Yes No Slip & Fall? Yes No

How did your problem begin _____

Date Problem began _____ Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? Yes No If yes, please explain:

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Burning Throbbing Shooting Tingling Gripping
 Dull Numbness Soreness Aches Weakness Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem better? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

What makes the problem worse? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

Can you perform your daily home activities: Yes Only with help Not at all

Do you exercise? Yes, almost daily Yes, occasionally Not at all

Describe your job requirements: Mainly Sitting Light Labor Heavy Labor

Can you perform your daily work activities: Yes, all activities Only some Not at all

Describe your stress level: None to mild Moderate High

SOUTHWESTERN CHIROPRACTIC CENTER
Patient Health Questionnaire

Patient Name _____

Acct# _____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancies |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling, Stiffness of Joints |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vision Disturbances |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pain - Neck | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Pain - Mid Back | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pain - Low Back | Height: _____ feet _____ inches |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pain - Arm/Elbow | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain - Hand | Weight: _____ pounds |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pain - Wrist | |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain - Ankle or Foot | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain - Leg | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pain - Knee | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> PMS | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rapid Heartbeat | |

For all patients over 13 yrs. old:

- Smoking - Packs/Day _____
- Alcohol - Drinks/Week _____
- Coffee/Caffeine Drinks - Cups/Day _____
- Alcohol Dependence
- Drug Dependence

Please list all allergies including allergies to medications _____

List all medications you are presently taking (including vitamins & supplements)

List any surgeries, fractures, serious illnesses or hospitalizations _____

Do you have a Living Will or Advance Directive? Yes No

In an emergency would you want CPR? Yes No

In an emergency would you want life support? Yes No

Pediatric Records: (under 17) Are your immunizations up to date? Yes No

Please provide complete immunization record.

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

- | | | | | |
|-------------------------------------|-----------------------------------|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | Other _____ | | | |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge.

I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

SOUTHWESTERN CHIROPRACTIC CENTER
Patient Insurance Information

Patient Name _____

Acct# _____

Please Note: We need to copy your insurance identification card for your file.

Is your Health Insurance yours through your employer, retired employer, or individual coverage? Yes or No

If YES, please go directly to the bottom of the page and provide your signature.

If NO, please provide the following information:

A. Subscriber Information: (Please complete A & B, if other than patient or lives at different address)

Subscriber Name _____ Birthdate ____/____/____ Phone (____) _____

Address _____ City _____ State _____ Zipcode _____

Relationship to patient _____ Subscriber's Social Security # _____

Employer Name _____ Work Phone (____) _____

Insurance Co. Name _____ Ins Co. Phone (____) _____

Insured's ID # _____ Group # _____

Is patient covered under any other insurance? Yes No If yes, please complete the following:

B. Second Insurance:

Subscriber Name _____ Birthdate ____/____/____ Phone (____) _____

Address _____ City _____ State _____ Zipcode _____

Relationship to patient _____ Subscriber's Social Security # _____

Insured's Employer _____ Work Phone (____) _____

Insurance Co. Name _____ Ins Co. Phone (____) _____

Insured's ID # _____ Group # _____

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION, AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Gioia all insurance benefits, if any, otherwise payable to me for the services rendered. If enrolled with an HMO and without the appropriate referral or authorization from my Primary Care Physician, I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Gioia to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as valid as the original.

Patient or Guardian Signature _____ Date _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Southwestern Chiropractic Center's Notice of Privacy Practices for protected health information. (Please see Privacy Notice posted on waiting room wall.)

Date: _____ Name of Patient (print) _____

Signature of Patient/Personal Representative _____

PATIENT COMMUNICATION AUTHORIZATION

Dr. Gioia and members of his staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. This contact could also be made through the mail on a postcard, and if you have referred someone to our office we need your authorization to use your name on our Honor Roll Board in the office waiting room. By signing this form, you are giving us authorization to contact you with these reminders and information and to use your name on our Honor Roll Board in the waiting room.
PLEASE REVIEW AND ASK ANY QUESTIONS BEFORE SIGNING.

Patient or Guardian Signature _____ Date _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _____ Date _____