Reminders

We remind our patients about upcoming appointments by either contacting you by telephone or text messages. Please check your preferred method of appointment reminders.

☐ Telephone

Phone number 1._____ Phone Number 2._____

☐ Text message

Mobile Number_____ Mobile Carrier (example Verizon)_____

I understand that my appoint times are reserved exclusively for me and if I do not give 24 hours notice for a cancellation, I will be charged for a missed appointment.

Name: _____

(Please print)

Signature: _____ Date: _____

VEHICLE ACCIDENT INFORMATION
PUTTY CHIROPRACTIC CENTER

Date: _____

Pt Name: _____ Date of Accident: _____ Time of Accident: _____

Employment at time of Accident: □employed □unemployed. Employer: _____ Ph: (____) ____-_____

Current employment: □ employed □ unemployed. Employer: _____Ph: (____) ____-_____

Type of work: □office/clerical □light labor □moderate labor □heavy labor

PAST MEDICAL HISTORY

Surgeries (dates)_____
_____
_____
_____

Serious illness (dates and residuals)
_____
_____
_____

Work comp injuries (date, treatment, rewards, residuals) _____
_____
_____
_____

Personal injuries (date, treatment, awards, residuals) _____
_____
_____
_____

Sports or other injuries to head, neck or back_____
_____
_____
_____

Fractures_____
_____
_____
_____

PAST MEDICAL HISTORY

Any prior history of current complaints
_____
_____
_____
_____

Treatment by other doctors for same complaint (dates and treatment)_____
_____
_____
_____
_____

VEHICLE

Year, make and model of vehicle you were in _____
_____

Year, make and model of other vehicles involved _____
_____
_____
_____

Your impact was from? □front □back □left □right □other
Your vehicle impacted: □nothing □another vehicle □structure □pedestrian □other _____

INJURY HISTORY

Was the crash on-the-job? □yes □no
You were: □driver □front seat passenger □rear seat passenger □other
If other please explain _____
Your estimated speed at moment of crash _____
You were: □stopped □slowing □accelerating □turning right □turning left
Time of day: □daylight □dawn □dusk □dark
Road conditions: □dry □damp □wet □snow □ice □other _____

Year, make and model of other vehicles involved _____
_____

Did the police come to the accident? □yes □no
Was police report filed? □yes □no
Was traffic violation issued? □yes □no if yes to whom? _____

Were you wearing seat belt? □yes □no □lap □shoulder If yes, do you have bruising or injury to that area (describe) _____

Does the vehicle have airbags? □yes □no Did airbags deploy? _____ if yes were you struck and where? ____
_____

Did your seat have a headrest? □yes □no If yes what was the position of the head rest? □low □mid □high
If adjustable was the position altered by the crash? □yes □no □don't know Was your seat broken? □yes □no

What was the position of your body at time of impact? Body: □straight □turned to the right □turned to the left □other
Head: □looking straight ahead □looking to the right □looking to the left □ other_____

Which hands were on the wheel? □both □right □left □NA Was your foot on the brake? □yes □no

Please describe the crash:

_____

_____

_____

_____

DURING THE CRASH

You were: □surprised by impact □braced for impact

Did your body strike any part of the vehicle? □yes □no If yes please describe_____

Wearing hat or glasses? □yes □no

If yes were they still on after the crash? □yes □no

Estimated damage to your vehicle

$_____

Estimated damage to other vehicle □ none □minimal □moderate □major

Did you go to the hospital? □yes □no If yes when did you go?

□immediately □next day □more than 2 days

If yes, did you go by □ambulance □friend/relative □yourself □other

Name of Hospital _____

x-rays/CT/MRI (list all reas)performed_____

_____

Treatment received _____

_____

Have you seen any other doctors for this problem? □yes □no

If yes, who and when _____

Please describe the reason for today's visit _____

_____

When did the symptoms first appear? □immediately after the crash □____ hours after the crash □____ days after the crash

Did you have loss of consciousness (LOC)? □yes □no If yes how long was the LOC _____

Do you remember the crash? □yes □no If no what is the last thing you remember before the crash _____

_____

Have you been able to work since the crash? □yes □no If no, how many day have you missed _____

Is the condition getting progressively worse? □yes □no □unknown

Please rate your level of pain (1-4) □1 minimal (no handicap just nuisance only) □2 slight (causes slight handicap)

□3 moderate (causes significant handicap) □4 sever (intolerable pain)

How often are you having the pain (% of the day)? □10% (rarely) □25% (occasionally) □50% (intermittently)

□75% (frequently) □100% (constantly)

Does your pain interfere with your: □work □daily routine □recreation □sleep □other _____

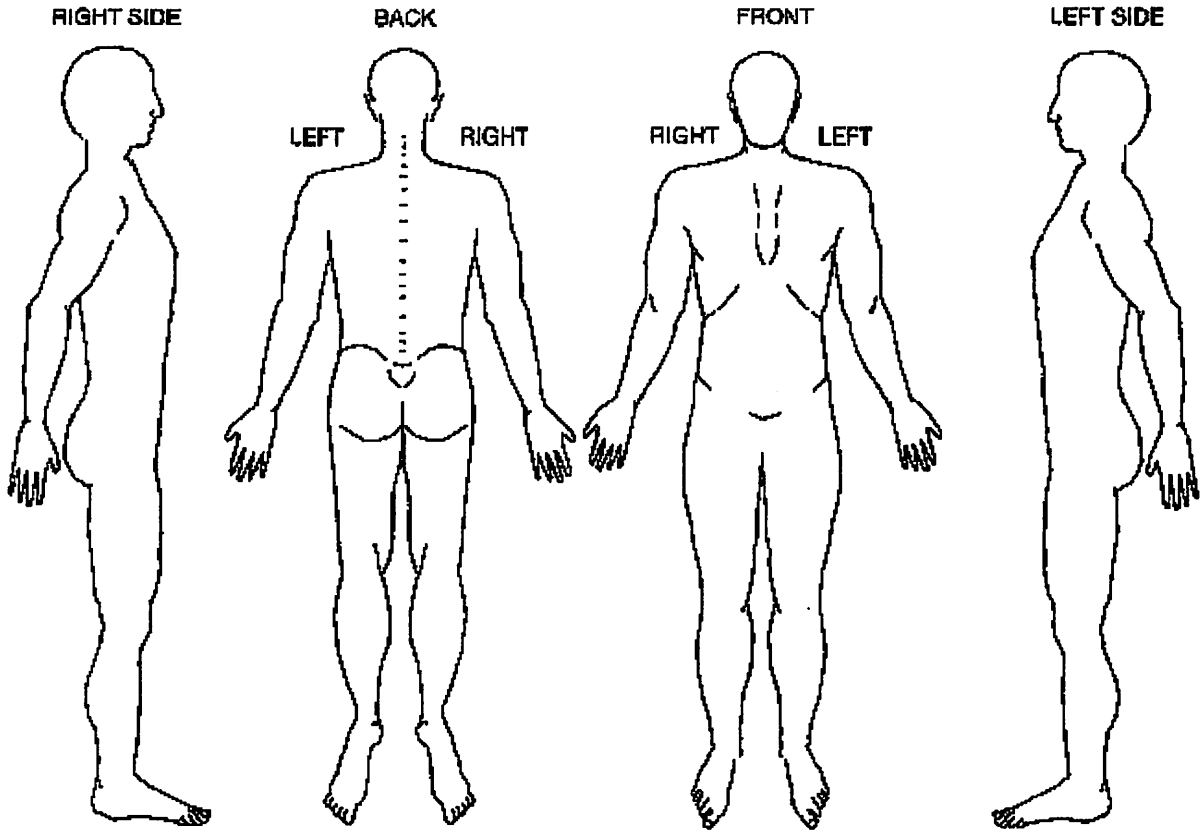
Which movements cause pain? □sitting □standing □walking □bending □lying down □lifting □coughing/sneezing

Have you had any of the following symptoms since your crash? Please check all that apply

□arm/shoulder pain	□feet/toe numbness	□nausea	□ vision blurred
□back pain	□hand/finger numbness	□neck pain	
□back stiffness	□headaches	□neck stiffness	
□chest pain	□irritability	□shortness of breath	
□dizziness	□jaw problems	□sleep difficulty	
□ear ringing	□leg pain	□stomach upset	
□fatigue	□memory loss	□tension	

Is your pain: □sharp □dull □throbbing □numbness □aching □shooting □burning □tingling □cramping □stiffness □swelling □fells like muscle spasms

PLEASE COMPLETE THE PAIN DRAWING BY MARKING THE APPROPRIATE AREAS OF PAIN



Please label the areas where you have pain. Use the following key:
A – ache B – burning N – numbness P – pins/needles S – sharp/stabbing O – other _____

Please draw simple diagram of the crash, labeling vehicles and direction of vehicles with arrows

PUTTY CHIROPRACTIC CENTER
REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Patient Name: _____
Date: _____ SSN: _____
Address: _____
_____
Email: _____
Birthdate: _____ Sex: □ M □ F Age: _____
□ Married □Widowed □Single □Minor
□Divorced □Partnered for _____ years
Employer/school: _____
Employer/school address: _____
_____
Employer/school ph: (_____) _____
Spouse/parent/guardian name: _____
Spouse/parent/guardian's employer: _____
Spouse/parent/guardian DOB: ___/___/_____
Spouse/parent/guardian SSN: _____

Referred by: _____

PHONE NUMBERS

Cell: (____) _____ Home: (____) _____
Best time to reach you _____ by □ cell □ home

EMERGENCY CONTACT: Name: _____
Cell: (____) _____ Home: (____) _____

ACCIDENT INFORMATION

Is this condition due to an accident? □ yes, □ no
Is this condition due to work related injury? □ yes □ no
If you answered yes to either question please fill out the personal injury form or the work related form.

INSURANCE INFORMATION

Who is responsible for this account?

_____
Relationship to Pt: _____
Insurance company: _____
ID#: _____
Is Pt covered by additional insurance? □Y □N
Subscriber's Name: _____
DOB: ___/___/____ SSN: _____
Relationship to Pt: _____
Ins Company: _____
ID#: _____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with _____
And assign directly to Dr. Putty all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance, I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of pt, parent, guardian or personal rep:
_____

Date:___/___/____

PATIENT CONDITION

Reason for visit: _____
When did your symptoms appear? _____ Give a brief description of what caused your symptoms: _____
_____
Have you seen any other doctors for this condition? □ yes □ no: If yes, who and when: _____
Please rate the severity of pain from 1(no pain) to 10 (worst pain I have ever had): _____
Is your pain: □ constant sever pain, □ constant but the intensity changes, □ comes and goes (at times I have no pain)
Have you ever had this problem in the past?_____ How long did it last? _____ If you have seen another doctor for the same pain please describe the treatment (medication, physical therapy, x-rays, MRI, chiropractic care etc...)_____
_____
_____

PUTTY CHIROPRACTIC CENTER
REGISTRATION AND HEALTH HISTORY

What treatment have you had for this condition? □ Medication □Physical therapy □Chiropractic □None □Other_____
Name of doctors or providers that have treated you for this condition _____
Date of last: □x-rays _____ □MRI/CT/bone scan/advanced imaging _____ □blood test_____
□physical exam_____ □urine test _____ □spinal exam_____

Please mark with an X to indicate if you have/had any of the following.

AIDS/HIV	( )	Diabetes	( )	Liver Disease	( )	Rheumatic Fever	( )
Alcoholism	( )	Emphysema	( )	Measles	( )	Scarlet Fever	( )
Allergy shots	( )	Epilepsy	( )	Migraines	( )	Sexually Transmitted Ds	( )
Anemia	( )	Fractures	( )	Miscarriage	( )	Stroke	( )
Anorexia	( )	Glaucoma	( )	Mononucleosis	( )	Suicide Attempt	( )
Appendicitis	( )	Goiter	( )	Multiple Sclerosis	( )	Thyroid Problems	( )
Arthritis	( )	Gonorrhea	( )	Mumps	( )	Tonsillitis	( )
Asthma	( )	Gout	( )	Osteoporosis	( )	Tuberculosis	( )
Bleeding disorders	( )	Heart Disease	( )	Pacemaker	( )	Tumors, Growths	( )
Breast lump	( )	Hepatitis	( )	Parkinson's Ds	( )	Typhoid fever	( )
Bronchitis	( )	Hernia	( )	Pinched Nerve	( )	Ulcers	( )
Bulimia	( )	Herniated disk	( )	Pneumonia	( )	Vaginal Infections	( )
Cancer	( )	Herpes	( )	Polio	( )	Whooping Cough	( )
Cataracts	( )	High Blood Pressure	( )	Prostate Problems	( )	Other : _____	
Chemical Dependency	( )	High Cholesterol	( )	Prosthesis	( )	_____	
Chicken pox	( )	Kidney Ds	( )	Psychiatric Care	( )	_____	
				Rheumatoid Arthritis	( )	_____	

Headaches (HA) ( ) How often do you have HA? _____ How long do they last? _____

Pregnancy history: # of pregnancies _____ # of live births _____ # of c-sections_____ # of vaginal deliveries_____
Are you currently pregnant? □ yes □ no If yes when is due date? _____
Any complications with this pregnancy or any past pregnancy? _____

Exercise:		**Work Activity:**		**Habits:**		
None	( )	Sitting	( )	Smoking	( )	Packs/Day: _____
Mild	( )	Standing	( )	Smokeless tobacco	( )	Cans/Day: _____
Moderate	( )	Light Labor	( )	Alcohol	( )	Drinks/Week: _____
Heavy	( )	Heavy Labor	( )	High Stress Level	( )	Reason for stress: _____

Injuries/falls/accidents: Please include date if possible
Surgeries:_____
Head injuries: _____
Broken bones: _____
Trauma: _____
Motor Vehicle Crash: _____

Medications: _____ **Allergies:** _____

PUTTY CHIROPRACTIC CENTER
ERIC PUTTY, DC

Consent to treatment

I hereby request and consent to the performance of chiropractic exam, adjustments and/or adjunctive therapies on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me which by working for or associated with or serving as back-up for the doctor named above.

I understand that results are not guaranteed and are informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time, based upon the fact then known, are in my best interest. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

Patient initial_____

Missed appointment policy

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance of appointment time. Patients who do not contact us prior to their appointment will receive a no-show charge of $35. Patients with frequently missed appointments will only be seen on a walk-in basis.

Patient initial_____

Financial obligation

You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all cost and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

Patient initial_____

Privacy Practices

I acknowledge that I have been given the opportunity to read a copy of Putty Chiropractic Privacy Practices and also receive a copy if I so choose. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient initial_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Print Patient Name

_____ _____

Patient Signature (or responsible party) **Date**

_____ _____

Witness **Date**

PUTTY CHIROPRACTIC CENTER

ERIC PUTTY, D.C.
260 BURLEY AVE.
HOPKINSVILLE, KY 42240

Patient Authorization for Disclosure to Designated Provider
Authorization to Release Medical Record Information

Type of Authorization: Designated Provider

Patient SS#_____

Patient Name (please print)_____ DOB_____

Purpose of request - I request and authorize the disclosure or release of my protected health information (as identified below) To / From (circle one) the following provider:

Name of practice_____

Name of provider_____

Address_____

City, State, Zip_____

Phone_____ Fax_____

Description of information to be disclosed - I authorize the disclosure of the following protected health information about me to the person(s) identified above:

____ Complete medical record (to include any or all information regarding HIV (aids) and testing, sexual abuse, spouse or child abuse, mental illness and substance abuse including controlled substance or alcohol abuse); or

____ Only the following:_____

_____

Purpose of disclosure - This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations.

Expirations or termination of authorization - This authorization will expire within _____ days from The date of my signature below.

_____ _____

Patient Signature Date

_____ _____

Signature of authorized person Relationship to patient

****

For office use only
Date records received_____ employee initials_____
Date mailed/faxed_____ employee initials_____

PUTTY CHIROPRACTIC CENTER

260 BURLEY AVE
HOPKINSVILLE KY42240
270-886-0068

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☒ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____