CROMSHAW CHIROPRACTIC CENTER DR. GIL CROMSHAW

GENERAL INFORMATION FORM

NAME:_____ DATE:_____

MAILING ADDRESS:_____

CITY/STATE:_____ ZIP:_____ SS#:_____

Cell Phone_____ Work Ph_____ Home Ph_____

E-MAIL ADDRESS:_____ DRIVERS LICENSE NO._____

BIRTH DATE:_____ AGE:_____ MALE / FEMALE SINGLE / MARRIED

EMPLOYER:_____

SPOUSE'S NAME:_____

SPOUSE'S EMPLOYER:_____

Payment Method: (skip if you were in auto accident): ( ) Cash/Check ( ) Credit Card ( ) ATM CARD

****Those filing health insurance: there is a minimum $50.00 charge until your insurance is verified

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It is usual and customary to pay for services as rendered unless otherwise arranged.

I HEREBY AUTHORIZE DR. CROMSHAW, OR HIS ASSISTANTS, TO EXAMINE ME AND MAKE ANY X-RAYS DEEMED NECESSARY BY THE DOCTOR. I FURTHER AUTHORIZE ANY TREATMENTS DEEMED NECESSARY BY THE DOCTOR INDICATED BY THEIR FINDINGS

BY SIGNING MY NAME, I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND TRUTHFUL. I FURTHER CERTIFY THAT I PRESENT TO DR. CROMSHAW FOR EVALUATION AND/OR TREATMENT FOR A HEALTH-RELATED CONDITION AND FOR NO OTHER PURPOSE.

SIGNATURE OF PATIENT:

X_____

IF MINOR, AUTHORIZATION BY ADULT: RELATIONSHIP TO :

X_____( )PARENT ( )GUARDIAN ( ) RELATIVE

ALL FEMALES PLEASE INITIAL BELOW!

_____*I do not feel that there is any possibility of being pregnant at this time. X-rays* may be taken if necessary

_____I am uncertain whether I am pregnant at this time.

AUTHORIZATIONS AND RELEASES

Name: _____ Date: _____

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office, hereby authorize Dr. Gilbert D. Cromshaw, Chiropractic Physician, and whoever may be designated as an assistant to administer treatment as is necessary.

I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself.

Furthermore, I understand that this office will prepare any necessary repots and forms to assist me in making collection from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. **I permit this office to endorse remittances for the conveyance of credit to my credit. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature: _____ Date: _____ Witness: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I authorize the release of any health care information necessary to process my insurance claim(s) and also certify that all insurance information given to Dr. Gil Cromshaw is correct and complete.

Patient's Signature: _____ Date: _____ Witness: _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____ (Insurance Company/Insurance Administrator) to pay by check and for it to be mailed directly to Dr. Gil Cromshaw with the expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional health care services rendered. I agree to pay, in a current manner, any balance of said professional charges. I hereby agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bills.

Patient's Signature: _____ Date: _____ Witness: _____

X-RAY / HEALTH CARE RECORDS RELEASE

I have requested the release of my x-rays and/or health care records which are part of the records at Cromshaw Chiropractic Center. In consideration of the foregoing, I hereby release Dr. Gil Cromshaw from responsibility arising from release of said materials, once delivered. I hereby acknowledge receipt of said materials or request that these materials be sent to the offices of Dr. Gil Cromshaw.

Patient's Signature: _____ Date: _____ Witness: _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, to protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover any fees for services. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make a payment on a current status.

I am also directing my attorney to pay any outstanding bills with any interest owed as outlined in the "Consent for Treatment" out of my settlement and, in effect, protecting such balance. **I fully understand that I am directly responsible for all health care bills and any interest owed and that this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment.**

Patient's Signature: _____ Date: _____ Witness: _____

CONSENT FOR TREATMENT FOR MINOR

I hereby authorize Dr. Gil Cromshaw and whomever may be designated as an assistant to administer treatment as deemed necessary to my _____ (indicate relationship of child) named _____.

Parent/Guardian Signature: _____ Date: _____ Witness: _____

CROMSHAW CHIROPRACTIC CENTER

PERSONAL HEALTH INFORMATION AUTHORIZATION

In accordance with our "Notice of Privacy Practices," we may disclose your personal health information to a family member, relative, friend or other person identified by you. Please below the names of ALL persons you would permit to have such access to your personal health information.

Name_____	___Spouse	___Parent	___Other
Name_____	___Spouse	___Parent	___Other
Name_____	___Spouse	___Parent	___Other
Name_____	___Spouse	___Parent	___Other

May we leave you a voice mail?	___Yes	___No
May we call you at work?	___Yes	___No

Please note: When calling to discuss medical information, we prefer to speak directly to the patient unless it is an emergency situation. Any person calling for you should be able to identify your date of birth, physician name and problem/procedure performed. This enables us to further protect your privacy. This authorization will continue until revoked or terminated by the patient in a written revocation received by Cromshaw Chiropractic Center.

CONSENT AND ACKNOWLEDGEMENT

I give Cromshaw Chiropractic Center my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care activities (quality reviews).

I have received the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain a copy of any revised notices of the practice.

I understand that I have the right to request a restriction for how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

If signed by patient representative, state relationship to patient - _____

FUNCTIONAL CAPACITY ASSESSMENT WORKSHEET

PATIENT NAME:_____

DATE:_____

Instructions: It is extremely important for clinical and insurance reasons that we be able to document in your chiropractic records you level of ability to *function.* It is no longer sufficient for us to simply document your pain level. This means we need to know how you are doing with a variety of *daily activities, movements, and positions.* Please answer the following to the best of your ability based on *how you have been doing for the past few days or up to a week. Circle or check the best answer!*

1. **Ability to SIT Without Significant Pain or Discomfort:**

0-15 mins. 15-30 mins. 30-45 mins. 45 mins. To 1 hr. 1-2 hrs. 2-3 hrs. 3 or more hrs.

2. **Ability to STAND Without Significant Pain or Discomfort:**

0-15 mins. 15-30 mins. 30-45 mins. 45 mins. To 1 hr. 1-2 hrs. 2-3 hrs. 3 or more hrs.

3. **Ability to SLEEP Without Your Discomfort Awaking You or Keeping You From Getting to Sleep:**

Can't sleep at all 1-2 hrs. 2-4 hrs. 4-6 hrs. 6-8 hrs. I have sleep problems unrelated to this problem

4. **Ability to BEND and TWIST the affected body part (Circle any) Neck Mid Back Lower Back**

No restriction at all Mild restriction Moderate restriction Major restriction

5. **Ability to WALK Without Significant Pain or Discomfort:**

No restriction I Can walk: 0-5 mins 5-20 mins. 30 mins 45 mins 60 mins 1-2 hrs 3-5 hrs

6. **Ability to LIFT various objects (you may check more than one here)**

_____I can lift heavy objects (20lbs. or greater) from the floor without extra discomfort

_____I can lift heavy objects from the floor but it causes extra discomfort

_____I can lift heavy objects if they are conveniently placed

_____I cannot lift heavy objects (20 lbs or greater) at all really

_____I can manage light to medium objects (1-15 lbs) without extra discomfort

_____I can only lift light to medium objects if they are conveniently placed

_____I can ONLY lift light weights (1-10 lbs.) at the moment

7. Ability to DRIVE in a Vehicle or SIT in a Vehicle Without Significant Discomfort:

No restriction 5-20 mins. 30-45 mins. 45 mins to 1hr. 1-2 hrs. 2-4 hrs.

8. Ability to PUSH or PULL with my arm because it causes pain in my shoulder

_____No real restriction on either

_____Mild trouble : PUSHING PULLING

_____Moderate trouble: PUSHING PULLING

_____Major trouble: PUSHING PULLING

9. Ability to carry out job JOB DUTIES:

_____This does not apply, I am not currently employed

_____No restrictions, I can do my job

_____Mild difficulties but I can still do my job

_____Enough difficulty that I can do some but not all of my job duties

_____I really can't do my job because of my discomfort

10. Ability to do tasks around my HOME OR LIVING AREA

_____I am able to do all the important tasks around my home (cleaning, washing clothes, cooking, etc.)

_____I am unable to do some, but not all of my home tasks (Unable to:_____)

_____I am unable to do most of what I should be able to do at home

11. Ability to TAKE CARE OF MYSELF (washing/bathing, going to bathroom, personal hygiene such as teeth brushing, combing hair, putting on clothes, etc)

_____No problems or restrictions

_____Mild problems but I still get everything done

_____Significant problems (Please describe:_____)

Patient Signature:_____

Date:_____

EHR Certification – Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) _____ Today's Date: _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell

Phone Call: ☐ Text Message: ☐

E-Mail: _____

Mailing Address: _____

_____

_____

OFFICE USE ONLY

Vitals: In EZnotes, complete by

1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

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

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:
Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

Timely access: In EZnotes, complete by

1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*"

☐ Completed?

Medications: In EZnotes, complete by

1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

☐ Completed?

Entered into EZnotes by (name): _____ Date & Time: _____

chiropractic

Bringing Out The Best In You!

Dr. Gil Cromshaw
Cromshaw Chiropractic Center
P.O. Box 1378, 304 Village Road
Leland, NC 28451
910-371-2525
CromshawChiro.com

Statement of Non-pregnancy & X-ray Consent

Patient_____

X-rays are one way of looking inside a person's body. **Chiropractors use X-ray analysis as one of the tools** that help tell if your body is properly balanced and if your vertebrae and other skeletal structures are in proper alignment. This helps us determine your **structural integrity.**

Long-standing nerve stress (subluxations) **may cause** a condition of inflammation of the bone and related structures and premature aging called **spinal degeneration**. An X-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For that reason **it is best to avoid X-rays when pregnant**. Please sign below so we may be able to proceed.

I, _____ , in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient's signature_____ Date _____

Doctor's signature _____ Date _____