PATIENT INFORMATION FORM

Welcome to Vital! Health! Please be complete and accurate. Your answers to the following questions are the first step in determining your immediate and long term health care needs. Please elaborate on any question or add any comments you may have...the more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank You!

Personal Information

First Name_____ MI____ Last Name_____ Preferred Name_____

Street Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

E-mail_____ D.O.B._____ Sex: M F Where did you hear about us?_____

Marital Status: S M W D Number of Children & Ages _____ Occupation_____

Health and Medical Information

What is your main health concern?_____

How long have you been experiencing this discomfort?_____ Are your symptoms: __Worse __Better __No Change

Did you injure yourself? If so, how?_____

What other aspects of your health are you dissatisfied with?_____

What are your personal health goals?_____

How long has it been since you've been well?_____ Please describe your health (circle): Excellent Good Fair Poor

Do you have allergies? __No __Yes If yes, please Indicate (foods, medications, other):_____

Do you have, or have you ever had, any of the following: (Circle all that apply) Hiatal Hernia Heartburn Stomach Stapled Heart Disease High Blood Pressure High Cholesterol High Triglycerides Diabetes Thyroid Disorder Goiter Appendicitis Anemia Pneumonia Measles Chicken Pox Epilepsy Influenza Mumps Alcoholism Pleurisy Mental Disorder Polio Whooping Cough Rheumatic Fever Cancer: _____

Have you had any of the following organs/glands removed? (circle those that apply) Gallbladder Uterus or Ovaries Appendix Thyroid Tonsils & Adenoids Any Other Body Part Removed?_____

Have you had any fractures, accidents, surgeries, or serious illnesses? If so, please list and include dates:

_____

Have you ever been treated by a chiropractor, acupuncturist or wholistic health practitioner? If so, by whom, when and for what condition? And, are you still seeing them?_____

Have you recently been under the care of a medical doctor? If so, whom, when and for what condition?

_____

Contagious History

Have you ever had or do you have a contagious illness that may require special procedures to protect our staff and other patients?

☐ Hepatitis ☐ Tuberculosis ☐ Venereal Disease
☐ Aids ☐ Herpes ☐ Other_____

Family History

	Heart	Kidney	Cancer	Diabetes
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Sibling	☐	☐	☐	☐

I have reviewed the information indicated on this questionaire and it is accurate to the best of my knowledge I understand that this information will be used to determine appropriate and healthful treatment. If there is a change in my medical status, I will inform my treating physician.

Signature_____ Date_____

In case of an emergency, whom should we notify? Name_____ Relationship_____

Phone Number_____ Address_____ City_____ State_____ Zip_____

CONSENTS AND AGREEMENTS

Patient Name _____ If minor, parent/guardian name _____

RESPONSIBILITY FOR PAYMENT: I, the undersigned, take full responsibility for payments of all services rendered by Provider and staff. If I, the undersigned, have insurance benefits available, I hereby understand that my insurance is a contract between myself and my insurance company and NOT between the Provider and my insurance company, and that I will be solely responsible for all billing and collecting from the insurance company for service rendered. Payment is due when service is rendered unless previous arrangements have been made.

_____

Signature of Patient or Parent/Guardian of Patient Date

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY: I, the undersigned, hereby authorize Provider and staff to release any information concerning my health acquired in the course of examination, history and treatment by the Provider to my insurance company which may be necessary to help process insurance claims.

_____

Signature of Patient or Parent/Guardian of Patient Date

AUTHORIZATION TO RELEASE INFORMATION (REPORTS, LABS, ETC.): I, the undersigned, authorize release of records as above to any other physician who is, was, or may be one of my treating physicians. In addition, I authorize release of information from previous physicians to Provider. This includes lab reports, test results and reports, x-rays, MRI's, etc. These authorizations include phone discussions between Provder and said physician, and the ability of Provider to read the above reports. I release Provider of any liability resulting from such information transference. WE ARE ALWAYS DILIGENT ABOUT DOUBLE CHECKING WITH YOU PERSONALLY BEFORE RELEASING ANY INFORMATION FROM YOUR FILE TO ANYONE.

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Signature of Patient or Parent/Guardian of Patient Date

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I, the undersigned, hereby authorize Provider and staff to release any information concerning my health acquired in the course of examination, history and treatment by Provider, outside lab reports, test results and reports, x-rays, MRI's, etc. to specific people listed below. These authorizations include phone discussions between Provider and named relative or significant other. Specific people authorized to discuss my medical information with (spouse, family member, etc.): _____

_____

Signature of Patient or Parent/Guardian of Patient Date

ADDITIONAL FEES: I, the undersigned, hereby agree to be charged, and to pay additional fees in the event that the following occurs:

1) We request that, out of courtesy to the doctor and other patients, at least 24 hours notice be given in the event that you need to change an appointment. We understand that emergencies may occur, making 24 hours notice impossible.

2) We reserve the right to charge a $50 fee in the event that 3 or more consecutive appointments are missed without 24 hours notice.

3) There will be a $25 fee charged for each returned check. Patient agrees to pay full amount of the returned check(s) plus the $25 fee, in cash, within ten (10) days of notification by the bank or office personnel.

_____

Signature of Patient or Parent/Guardian of Patient Date

COMMUNICATION: As part of our patient orientation process and in our ongoing efforts to provide you with important information to help you improve your health, we send regular e-mails to our patients. On occasion, we may also send text or mail messages as well. Would you like to receive: **Emails:** ☐Yes ☐No **Texts:** ☐Yes ☐No **Mail:** ☐Yes ☐No

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Signature of Patient or Parent/Guardian of Patient Date