

**\*PLEASE FILL OUT ALL FIELDS ON ALL PAGES\***

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Married: (Circle) Yes No Spouse Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Relation: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Employed at: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work Duties: \_\_\_\_\_

May we **contact you** regarding your care at this office and/or **your health records**? Yes No

Can we **leave a message** on the phone numbers listed above? Yes No

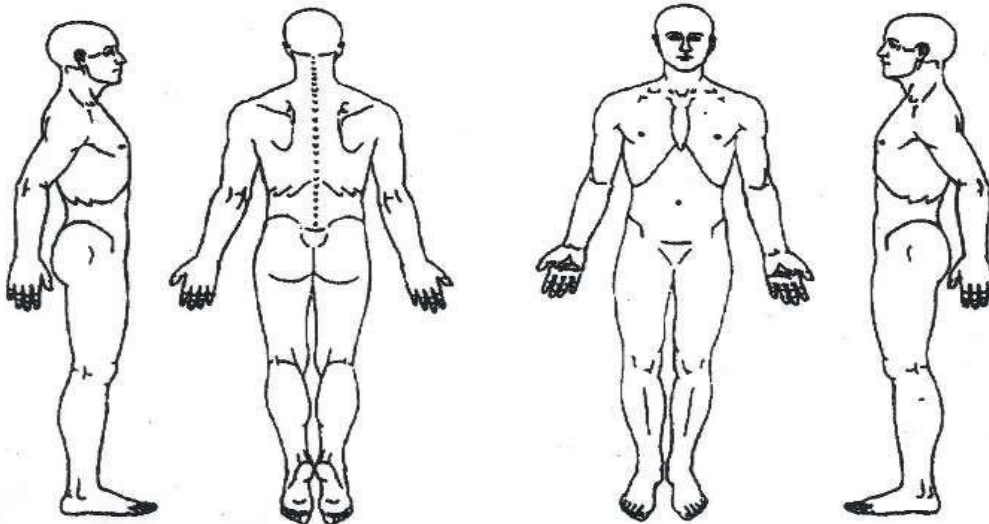
*CMS requires providers to report both race and ethnicity*

**Race (Circle One):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific islander / I Decline to Answer

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

How did you hear about us: \_\_\_\_\_

Please circle area of primary complaint **BELOW**:



Briefly describe your pain. (sharp, shooting, etc.)

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203 Shaw Ave.  
 Harrington, DE 19952  
 Phone: 302-682-7975  
 Fax: 302-566-6046

[www.delmarvawellness.com](http://www.delmarvawellness.com)

**Medical History**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_ Primary Phys: \_\_\_\_\_ Phys Phone #: \_\_\_\_\_

Phys City: \_\_\_\_\_ Phys State: \_\_\_\_\_ Phys Zip: \_\_\_\_\_

Previous Chiro Care: (Circle) **Yes** **No** Date: \_\_\_\_\_ Explain: \_\_\_\_\_  
 Surgery: (Circle) **Yes** **No** Explain: \_\_\_\_\_  
 Hospitalized: (Circle) **Yes** **No** Explain: \_\_\_\_\_  
 Chance Pregnant: (Circle) **Yes** **No** Planning: (Circle): **Yes** **No**  
 Auto Accident (Circle): **Yes** **No** Treatment (Circle): **Yes** **No** Explain: \_\_\_\_\_  
 Other Previous **Yes** **No** Treatment (Circle): **Yes** **No** Explain: \_\_\_\_\_  
 Trauma/Injury (Circle):  
 Struck Unconscious (Circle): **Yes** **No** Treatment (Circle): **Yes** **No** Explain: \_\_\_\_\_  
 Stroke: (Circle) **Yes** **No** Explain: \_\_\_\_\_

**Please list any medical conditions, including any prescribed medications.**

Medical Conditions (Please List All)	Medication	Dosage and Frequency (i.e. 5mg daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you have any medication allergies?**

Medication Name	Reaction	Onset Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History:	MEDICAL CONDITION(S)	LIVING Y/N
<b>Mother:</b>	_____	_____
<b>Father:</b>	_____	_____
<b>Sibling(s)</b>	_____	_____
<b>Children:</b>	_____	_____

**Smoking:** Daily Weekly Occasion Never Former **Vape:** YES NO  
**Alcohol:** Daily Weekly Occasion Never **Caffeine:** Daily Weekly Occasion Never  
**Recreational Drugs:** Daily Weekly Occasion Never **Exercise:** Daily Weekly Occasion Never

**Health Checklist (Please check all that apply)**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cramps	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eye Pain or Difficulties/Vision Disturbance
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	

**Primary Care Physician Communication**

**We will communicate with your Primary Care Physician** listed on the previous form by sending your initial exam, periodical exams, and clinical notes. **Dr Riggin recommends communication with your Primary Care Physician if possible.**

**Communication Options (Please Check One)**

- Yes**, please communicate with my physician
- No**, I would like to **opt out** of communicating with my physician
- I do not have a Primary Care Physician

**Cancellation/No Show Policy**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to cancelling your appointment. After 2 missed appointments within 30 days, we reserve the right to assess a \$20 charge. To avoid missed appointments, our office will text/email you to confirm your appointment.

- I would like to get appointment reminders by TEXT**
- I would like reminders sent to my EMAIL**

**Statement of Patient Financial Responsibility**

As an elective participant in our chiropractic services, you are ultimately responsible for the payment of your bill in full. You are responsible for payment of any deductible and co-pay/co-insurance as determined by your insurance carrier. We expect any billed balances within 30 days of patient bill being received. If your insurance denies any part of your claim, or if you elect to continue past your approved period, you will be responsible for your balance in full.

**I agree to the above mentioned financial responsibility and cancellation policies:**

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Informed Consent to Chiropractic Adjustments and Care**

I consent to the performance of chiropractic adjustments and other chiropractic procedures on me including various modes of physical therapy or diagnostic x-rays by Dr. Jesse Riggan and/or other licensed Doctor of Chiropractic employed at this practice.

I understand that there are some risks to chiropractic treatment including, but not limited to, fractures, discs injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate all possible risks and complications, however I wish to rely on the doctor to act in my best interests based upon the facts known.

I have read, or have had read to me, the above consent. I have had the opportunity to discuss with Dr. Riggan the nature and purpose of chiropractic procedures as well as the associated risks. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

### **Acknowledgment of Receipt of HIPPA Notice of Privacy Practices**

I hereby acknowledge that I have received a current copy of Delmarva Chiropractic and Wellness Center's "Notice of Privacy Practices" (**available upon request**). A representative of DCWC has explained the "Notice of Privacy Practices" to my satisfaction. I am aware that DCWC has included a provision that it reserves the right to change the terms of its notice. I have read the Privacy Notice (Ref. form 2016.7.19) and understand my rights contained in the notice. By way of my signature, I provide DCWC with my authorization and consent to disclose my protected healthcare information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

### **HIPPA Requests (You Must Check One)**

- I wish to file a "**Request for Restriction**" of my Protected Health Information.
- I wish to file a "**Request for Alternative Communications**" of my Protected Health Information.
- I wish to object to the following in the "**Notice of Privacy Practices**".
- I agree with the current policy.

I have read and agree to the "**Informed Consent to Chiropractic Adjustments and Care**" as well as the "**Acknowledgment of Receipt of HIPPA Notice of Privacy Practices**". I certify that I am the patient or legal guardian listed below and that the included information is true and accurate to the best of my knowledge.

**\*\*\*If the patient is under the age of 18, a parent must sign this form and be present for the initial appointment.**

**\*\*\*Parent Name (Printed):** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_