DELMARVA CHIROPRACTIC
AND WELLNESS CENTER

1000 Midway Drive, Suite 11A
Harrington DE, 19952
Phone: 302-682-7975
Fax: 302-566-6046
www.delmarvawellness.com

PLEASE FILL OUT ALL FIELDS ON ALL PAGES

Date: ___/___/_____ 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: _____

Email: _____

Employed at:_____ Occupation: _____

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 _____

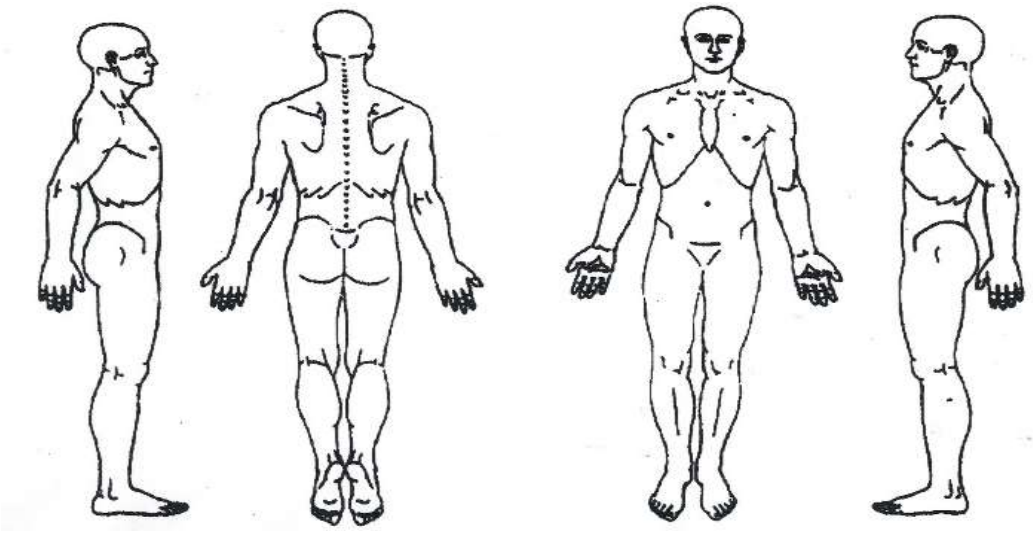
CMS requires providers to report both race and ethnicity

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 <u>BELOW</u>:



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

_____

_____

For office use only

Height: _____ Weight:_____ Blood Pressure: ____/____ BPM: _____

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Medical History*

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:_____

Struck Unconscious (Circle): Yes No Treatment (Circle): Yes No Explain:_____

Stroke: (Circle) Yes No Explain: _____

Pleas list any medical conditions occurring in the last five years, including any prescribed medications.

Medical Conditions	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
Mother:		
Father:		
Sibling(s)		
Children:		

Smoking Status (Circle One): Every Day Occasional Former Never

Alcohol: Daily Weekly Occasion Never **Caffeine:** Daily Weekly Occasion Never

Recreational Drugs: Daily Weekly Occasion Never **Exercise:** Daily Weekly Occasion Never

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Health Checklist (Please check all that apply)

Name: _____DOB:_____

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

If you need to cancel your appointment for any reason, please call at least 24-hours in advance. To avoid missed appointments, our office will email/text you a reminder of your appointment date and time.

- ☐ **I would like to get appointment reminders by TEXT**
  - **Cell Phone Provider: (please circle) Verizon – AT&T – Other: _____**
- ☐ **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:_____

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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 Riggin 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. Riggin 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" **(which is located on the bottom of the clipboard)**. 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.

Patient Name: _____

Patient/Guardian Signature: _____

Date:__/__/____