SHERROD CHIROPRACTIC
2512 Alexander Drive, Ste B, Jonesboro, AR 72401
(870)934-8481 | www.dcjason.com

1 Patient Information

NAME_____

Date:_____ Patient SSN_____

Address_____

City_____State____Zip_____

Email_____

Sex: ☐ M ☐F Age____ Date of birth_____

☐Single ☐Married ☐ Widowed ☐Separated ☐Divorced

Occupation_____
Employer_____
Employer Addr:_____
Spouse's Name_____
Spouse's DOB_____

Whom may we thank for referring you?

_____

2 Insurance

ID#_____

☐Auto Insurance Claim ☐Commercial Insurance
☐No Insurance (Self Pay) ☐Medicare
☐Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Sherrod Chiropractic, PLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 Phone Number

Main (_____)_____-_____

May we remind you of your appointment via text msg?
☐Yes ☐ No

Name of Phone carrier
☐AT&T ☐Verizon ☐Sprint ☐Other_____

IN CASE OF EMERGENCY, CONTACT:
Name_____
Relationship_____Phone_____

By supplying your number, email address or any other contact information, I authorize Sherrod Chiropractic, PLC to employ a third party automated messaging system to: use my personal health information, the name of my provider, the time date and place of my pending appointment, a missed appointment, or other communications. I authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Signature_____ Date_____

4 Accident Information

Is Condition due to an accident? ☐Yes ☐No
Date of accident _____

Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?
☐ Auto Ins ☐ Employer ☐ Work Comp ☐ Other

Information for Auto Claims only:

Name of Auto Insurance:_____

Claim number_____

Phone number_____

Adjuster's Name_____

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Name:_____

Patient Summary

Describe the Reason for this Visit:_____

When did your symptoms begin?_____

On a scale from 1 to 10, how bad is the discomfort at its worst? ____/10 versus now?____/10

Has this concern ☐gotten worse ☐stayed constant ☐come and gone

Was the onset of the discomfort: ☐Gradual or ☐Sudden

What aggravates the discomfort?_____

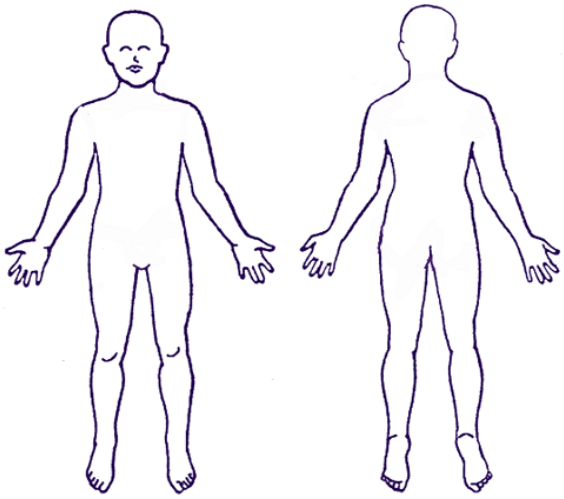
Duration of Pain: ☐All Day ☐75% of day ☐50% of day ☐25% of day

Is the pain: Dull/Throbbing/Tingling/Aching/Stabbing/Sharp/Shooting/Tightness/Numbing/Other

What relieves the discomfort?_____

In general, would you say that your overall health is:

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor



Other comments:

_____

_____

_____

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Name:_____

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Health History

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical therapy ☐Chiropractic Services ☐None ☐Describe_____

Name and address of other doctor(s) who have treated you condition_____

Date of last: Physcial Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urin Test_____
Dental X-ray_____ MRI, CT Scan, Bone Scan_____

Please place a mark to indicate if you have had any of the following:

☐Aids/HIV	☐Emphysema	☐Migraine Headaches	☐Rheumatic Fever
☐Alcoholism	☐Epilepsy	☐Miscarriage	☐Scarlet Fever
☐Allergy Shots	☐Fractures	☐Mononucleosis	☐Stroke
☐Anemia	☐Glaucoma	☐Multiple Sclerosis	☐Suicide Attempt
☐Appendicitis	☐Goiter	☐Mumps	☐Thyroid Problem
☐Arthritis	☐Gout	☐Osteoporosis	☐Tonsillitis
☐Asthma	☐Heart Disease	☐Pacemaker	☐Tuberculosis
☐Bleeding Disorders	☐Hepatitis	☐Parkinson's Disease	☐Tumors/Growths
☐Breast Lump	☐Hernia	☐Pinched Nerve	☐Typhoid Fever
☐Bronchitis	☐Herniated Disk	☐Pneumonia	☐Ulcers
☐Cancer	☐High Cholesterol	☐Prosthesis	☐Whopping Cough
☐Chemical Dependency	☐Kidney Disease	☐Prostate Problem	Other_____
☐Chicken Pox	☐Liver Disease	☐Psychiatric Care	_____
☐Diabetes	☐Measles	☐Rheumatoid Arthritis	

Exercise	**Work Activity**	**Habits**	
☐None	☐Sitting	☐Smoking	Packs/Day_____
☐Moderate	☐Standing	☐Alcohol	Drinks/Weeks_____
☐Daily	☐Light Labor	☐Coffee/Caffeine	Drinks/Weeks_____
☐Heavy	☐Heavy Labor	☐High Stress Level	Reason_____

Are you pregnant? ☐**Yes** ☐**No** **Due Date**_____

ANY! Injuries/Surgeries you have had: **Description** **Date**

Significant Falls _____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

For office use only

Height: _____ Weight: _____ Blood Pressure:_____/_____ Heart rate:_____ O2: _____

Resp:_____ Temp: _____ Ortho: _____ Neuro: _____ X-Rays_____

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Name:_____

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By my signature below, I authorize Sherrod Chiropractic PLC to release any information deemed appropriate to any doctor, insurance company or attorney in the course of treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Sherrod Chiropractic PLC. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over to collections, I understand that I will be responsible for any charges, attorney fees, collection costs and court costs incurred in collecting the balance.

Chiropractic Adjustment: The doctor will use his/her hands or a mechanical device in order to adjust your spinal joints. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a 'click' or a 'pop' as well as a movement of the joint. Various ancillary procedures such as, support pillows, cold laser, traction or hot/cold packs may also be used. **Risks:** As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.
Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been described as 'rare'. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be 'rare'.
I have had the risks of my case explained to me. If you/and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.
Patient Authorization: I have read or have had read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

(CMS requires providers to report the following for the government HER incentive program)

Patient's Preferred Language: _____

Smoking Status (circle one): Every day Smoker / Occasional Smoker / Former Smoker / Never Smoked

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 use reverse of this page to complete, and include regularly used over the counter medications)

Do you have allergies to medications, or any other allergies? _____

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.)

I received a copy of notice of Privacy Practices.

Signature_____ Date_____

If Minors, Parent/Guardian Signature_____ Date_____