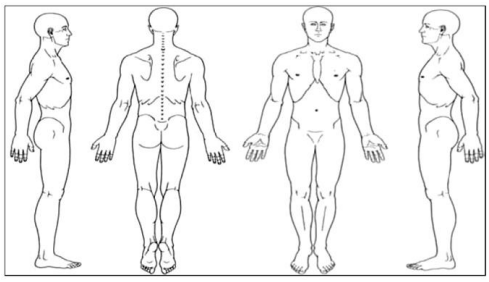
Triumph Chiropractic
Your Health & Wellness Experts

New Patient Form:

Patient Name: _____Social Security: _____-_____-_____
Email: _____ Address: _____
City: _____ State: _____ Zip:_____ Age:_____ Birth Date: ___/____/____
Sex: ☐M ☐F Marital Status: M - S - D - W Number of Children: _____
Cell Phone # ( ) _____ - _____ Cell Phone Carrier(ie: verizon): _____
Occupation: _____Work Phone # ( ) _____ - _____ext._____
Employer:_____ Employers Address: _____
Spouse's Name: _____Occupation: _____
Whom may we thank for referring you? _____
Purpose of this Appointment: _____
What types of treatment have you already received for your condition? ☐Medication ☐Surgery ☐Chiropractic Care☐Physical Therapy ☐None ☐Other_____
Do you have a Primary Care Physician? ☐No ☐Yes, Name & Phone # _____
Have you ever had Chiropractic Care before? ☐No ☐Yes -- Dr.'s Name_____
Are you taking medication? If so please list them_____
List surgical operations and years _____

Please indicate areas of pain:



What functions are you unable to perform, or induce pain upon doing so? (example: sit, bend, walk, sleep, etc.) _____
List conditions you are interested in getting corrected in order of importance:
1. _____
2. _____
3. _____
4._____

Women: Are you pregnant at this time? ☐No ☐Yes – Due date _____
Have you ever suffered from:
☐Dizziness ☐Neck Pain ☐Backaches ☐Diabetes ☐Neuritis ☐Nervousness ☐Cancer ☐High Blood Pressure ☐Sinus trouble ☐Headaches ☐Arthritis ☐Digestive disorders ☐Asthma ☐Allergies ☐Heart Trouble

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION:

Is your case: ☐Workers Compensation ☐No-Fault (car accident) ☐Personal Injury
Date of injury:_____Time:_____Location:_____
Please describe how injury happened: _____
_____
Did you report your injury? ☐No ☐Yes – To whom? _____
Were you hospitalized? ☐No ☐Yes – Where? _____
By ambulance? ☐No ☐Yes , Were X-rays taken? ☐No ☐Yes – By whom? _____
Date(s) of hospitalization_____ Medication(s) prescribed_____
Are you presently working? ☐No ☐Yes – Dates of time lost from work _____
Have you been treated by any other chiropractor or physician for this injury? ☐No ☐Yes
If yes, Doctor's name & specialty_____
Attorney Name(if applicable) _____

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Insurance Information:

Do you have Health Insurance? ☐No ☐Yes – If yes, please continue:

Insurance Co. _____Are you the policy holder? ☐No ☐Yes

Address_____ Group #_____

ID #_____ Phone number _____

Are you covered by any additional insurance? ☐No ☐Yes – If yes, please continue:

Policy Holder's Name_____ Birth Date ___/___/___

Relationship to Patient _____ Social Security: _____-_____-_____

Insurance Co._____

Address_____ Group #_____

ID #_____ Phone number _____

Do you have an account to help with healthcare costs? If so what type; ☐HSA, ☐FSA, ☐HRA

ASSIGNMENT AND RELEASE

I Certify that I, and/or my dependent(s), have insurance coverage with Ins Co._____ and assign directly to Dr. Rodnick and/or Triumph Chiropractic PLLC 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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please Print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

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Acknowledgment of Notice of Privacy Practices:

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Dr. Alex Rodnick
424 S. Main Street, Northville, MI 48167
734-237-8916

This notice is effective as of September 23, 2013. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient