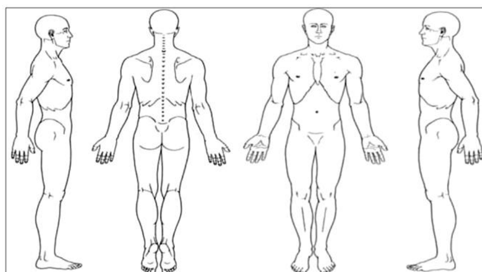
New Patient Form:

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) ____

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 _________________________________

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
20216 Farmington Rd
Livonia, MI 48152
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