# Active Health Chiropractic

Dr. Justin R. Jenkins DC
415 W. Tabernacle, St. George, UT 84770
(435) 673-2700 Phone | (435) 673-2714 Fax

## Patient Information

Legal First Name:_____ MI:_____ Last Name:_____

Street:_____ Apt:_____

City:_____ State:_____ Zip:_____

Birth Date:_____ Martial Status: S M W D Spouse:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Cell Phone Carrier:_____ (for text message reminders and notifications)

We may need to contact you, check which option you prefer us to use when contacting you:

□ Cell Phone □ Home Phone □ Work Phone □ Text Message
□ Home Email □ Work Email □ Post Mail

Email home:_____ Email work:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone Number:_____

Whom may we thank for referring you to our office?_____

## Insurance Information

*We will make a copy of your insurance card(s). However, please complete the following information.*

Are you the policy holder? Yes No If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name:_____ M.I._____ Last Name:_____

Policy Holder's Date of Birth:_____ Policy Holder's SS#:_____

Policy Holder's Employer:_____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name:_____ M.I._____ Last Name:_____

Policy Holder's Date of Birth:_____ Policy Holder's SS#:_____

Policy Holder's Employer:_____

**Patient Name:_____ DOB:_____ Date:_____**

***Due to recent changes in the healthcare industry, we are asked to obtain the following information on patients treated in our office.***

**General Information:**

Language: □ English □ Spanish □ Indian □ Japanese □ Chinese □ Korean
□ French □ German □Russian □ Other_____

Race: □ White □ American Indian or Alaska Native □ African American
□ Hispanic or Latino □ Asian □ Native Hawaiian/Other Pacific Islander
□ Decline to Answer

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Answer

**Patient History**

Are you seeing anyone else for other problems or health conditions? Yes No
Please list the condition/problem, date condition began, and Provider(s) treating you for the condition(s).

_____
_____
_____

**Past Health History**

Have you been: If yes, include date & name of Provider:
Hospitalized in the last 5 years? Yes No _____
Diagnosed with Diabetes Yes No _____
□ Type I □ Type II

Do you smoke? □ Never □ Former Smoker
□ Current/Every Day Smoker -- # of packs/day_____ for _____ years
□ Current Occasional Smoker

**Medications**

What medications are you currently taking? Include vitamins, herbs, minerals….
(If you have a list already made, please provide a copy)
List Date Started, Name, Strength, Dosage, Frequency, Duration, Quantity, Prescribed by
Please be as specific as possible

_____
_____
_____
_____

Do you have any allergies? □ Food □ Environmental □ Medication
List Type of Allergy and Reaction_____
_____

**Vitals (for office use only)**

Height_____ Weight_____ Blood Pressure_____

# Assignment and Release

## Assignment of Benefits and Instruction for Direct Payment to Doctor

I hereby instruct and direct _____
Insurance Company, to pay by check, made out and mailed directly to:

Dr. Justin Jenkins and/or Active Health Chiropractic
415 W. Tabernacle St.
St. George, UT 84770

or to make a bank direct deposit into such account as designated by Dr. Jenkins, the professional or Medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for Professional Services rendered by the Active Health Chiropractic clinic. The payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in the current manner, any balance of said Professional Service charges over and above this insurance payment.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Active Health Chiropractic Office/Staff will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account on receipt of payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable* and further agree to pay the actual expenditures incurred in any attempt to collect the amount due, including reasonable attorney's fees and costs.

*A finance charge of 1.5% per month (annual percentage rate 18%) will be applied to any amount not paid after 60 days.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient/Parent/Guardian Signature: _____ Date: _____

## Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he seems necessary in my case. I furthermore authorize him to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office, or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____ Date:_____

Witness:_____ Date:_____

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Dr. Justin Jenkins D.C.**
**415 W. Tabernacle St.**
**St. George, Utah 84770**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Printed): _____

Relationship to Patient: _____

Signature: _____

Date: _____

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

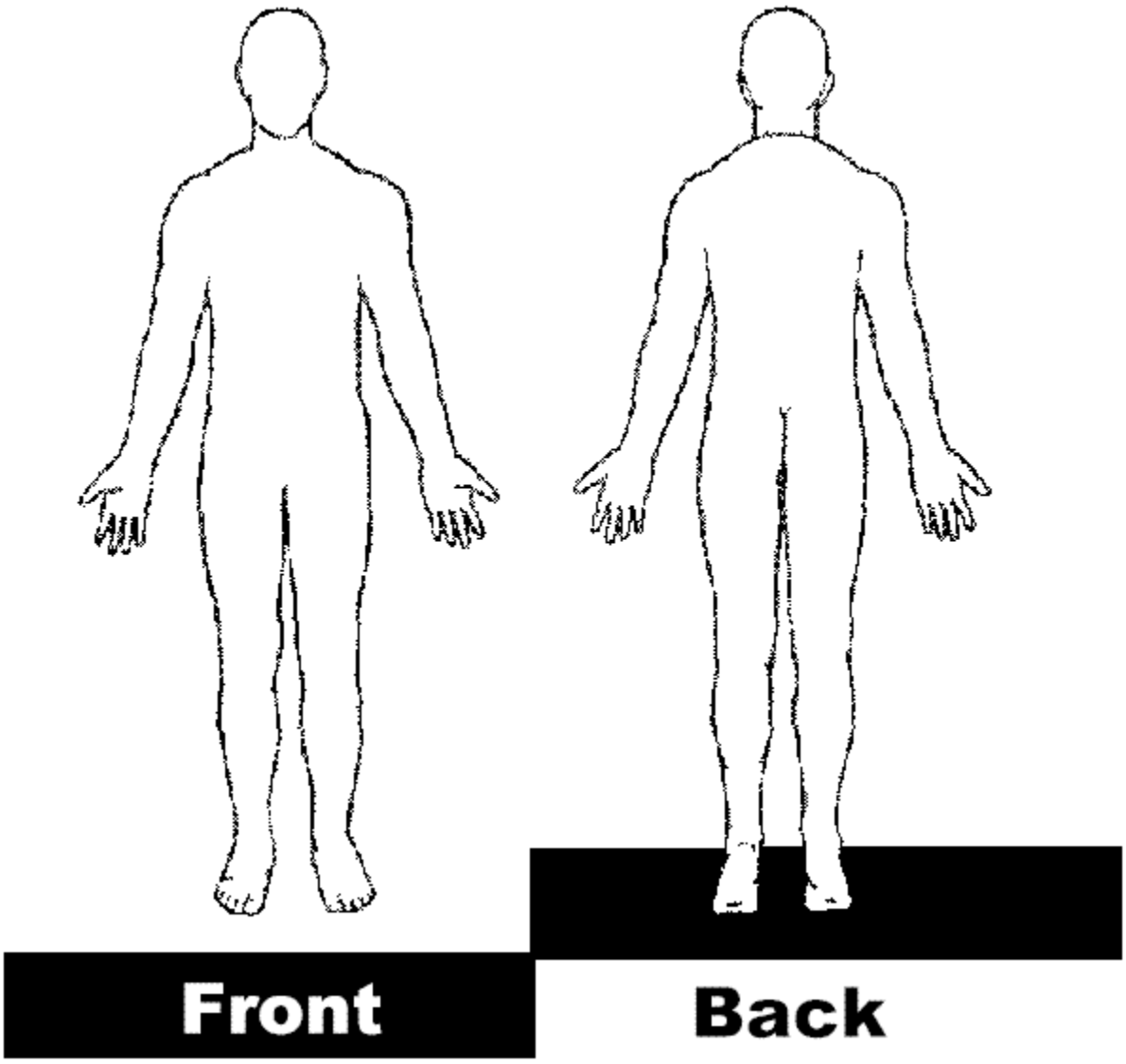
NAME: _____ DATE: _____

# DALLAS PAIN DRAWING GRID ASSESSMENT

Draw the location of your pain on the body outline below. Mark its severity on the pain bar at the bottom of the page.

| ACHE | BURNING | NUMBNESS | PINS & NEEDLES | STABBING | OTHER |
|---|---|---|---|---|---|
| AAAA | = = = = = | ○ ○ ○ ○ | . . . . . | / / / / / | x x x x |

Percentage of pain in back _____ Percentage of pain in legs _____




0 10

# QUADRUPLE VISUAL ANALOGUE SCALE

NAME:_____ DATE:_____

INSTRUCTIONS: Please circle the number that best describes the question being asked.
Note: If you have more than on complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

EXAMPLE:

Headache Neck Low Back

0 1 (2) 3 (4) 5 6 7 8 (9) 10

**********

1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain AT ITS WORST (How Close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

5. What percentage of your awake hours is your pain at its best?_____%

6. What percentage of your awake hours is your pain at its worst?_____%