CHARLESTON Neck & Back CENTER

Today's Date: _____

Yearly Patient Up-date Form

****Please give the front desk a copy of your current insurance card****

Please Print Clearly

_____ _____ _____ _____
Legal First Name | Middle | Legal Last Name | Preferred Name

_____ _____ _____ _____ _____
Mailing Address | Apt. # | City | State | Zip

_____ _____ _____ _____
Home Phone | Cell Phone | Employer | Work Phone

_____ Male / Female
Email Address (We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.) | Gender (Circle one)

Preferred communication for patient reminders (circle one): Phone /Text/Email **Preferred Language**:_____

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 / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Health History

Are you currently pregnant? **Yes** **No** If yes, how long have you been pregnant? _____

Do you have a pacemaker or implantable cardioverter-defibrillator (ICD)? **Yes** **No**

Do you have any metal implants? **Yes** **No** If yes, where? _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Height:_____ Weight:_____ Blood Pressure: _____/_____

Are you currently taking any medications? (include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Charleston Neck & Back Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Charleston Neck & Back Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____
Consent to treat a Minor | Date

_____
Guardian or Spouse's Signature of Authorizing Care | Date

_____
Patient (Print Name) | **Patient's Signature** | **Date**

☐ **I choose to decline to receive a clinical summary after every visit** *(Checking this box will eliminate the need to print a summary after each visit. This summary s often blank as a result of the nature and frequency of chiropractic care.)*