CONFIDENTIAL PATIENT INFORMATION

Name_____ Home Phone_____
Last, First, M Nickname

E-mail address _____ Cell Phone _____

Home Address_____ City_____ St_____ Zip_____

Mailing Address _____ City _____ St ____ Zip _____

Social Security # _____ Birthdate _____ Sex: M___ F ___

Employer_____ Work Phone_____

Work Address_____ City_____ St____ Zip_____

Spouse's Name_____ Work Phone_____

Person financially responsible for this account_____

Relationship to patient_____ Phone_____

In case of emergency contact_____ Phone_____

Name of nearest relative not living with you _____ Phone _____

Is your present condition a result of an auto accident? Yes___ No ____
Other Accident? Yes ___ No ___ Injury that occurred on the job? Yes ___ No ___
(If yes to any of the above, please see receptionist for supplemental forms)

How did you hear of Brockman Family Chiropractic? _____

I will be paying today by: Cash ___ Check ___ American Express ___ Visa ___ MC ___

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and 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 and treatment, any fees for professional services rendered me will be immediately due and payable. In case of default on my part, and it is necessary for this office or its agent to employ legal and/or a collection counsel, I hereby agree that I am responsible for collection charges incurred, which will be added to my bill. I have read and understand the financial policy and hereby agree to fulfill my financial obligation according to the financial rules presented there. I certify this information is true and correct to the best of my knowledge.

Patient/Guardian signature_____ Date_____

I acknowledge that I have had the opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice. _____Initial

Informed Consent

It is our responsibility to inform you of significant risks of your treatment. Part of this includes a discussion of potential side effects or complications. All treatments potentially can cause side effects, and chiropractic manipulation is no different. It however, has one of the safest records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

Disc injury from manipulation causing spinal cord pressure	Neurologic complication from Neck surgery	Back surgery
1 per 100 million	1 per 64	1 per 333

Artery injury from manipulation causing stroke	Death rate from neck surgery
1 per 1 million	1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs. These drugs cause fairly common and potentially serious complications.

Complications associated with anti-inflammatory drug use:

* Serious stomach or intestinal bleeding	1-4 per 1000 users
* Hospitalizations from complications	20,000 per year
* Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Brockman Family Chiropractic.

Patient's_____Signature_____Date_____
Name (Guardian's if minor)

Brockman Family Chiropractic, Dr. Marjorie A. Brockman, DC, 445 Idaho Street, Gooding, ID 83330 208-934-5000

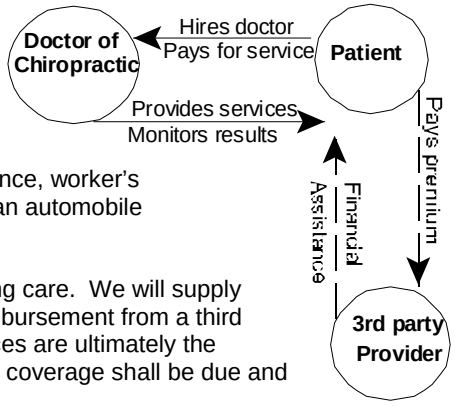
PT#_____

FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide and when they are performed.

Procedure	Purpose	When Performed	Fee
Consultation	Tour the office, meet the doctor, discuss your health, review your case history.	First Visit	N/C
Evaluation/ Management [Examination(s)]	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, exacerbations, and re-examinations.	$95-$130
X-Rays	Visualize the location of spinal problems and confirm other examination findings.	If necessary, first visit, re-injuries and at certain progress examinations.	$50-$100 Per View
Adjustment	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problem.	As indicated by examination or evaluation.	$37-$45
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.	$16-$45

Forms of Payment:
Patients are responsible for full payment at the time of service. We accept cash, personal check, Visa, American Express and Mastercard. Payment in full is expected at time of service. Any special arrangements must be made with office staff in advance.



Insurance/Contract Services/Third Party:
Other options are available if your care is covered by group health insurance, worker's compensation, a managed care provider, personal injury or the result of an automobile accident.

All professional services are rendered and charged to the patient receiving care. We will supply you with statements, reports or other documents to help you receive reimbursement from a third party. Your primary insurance provider is billed as a courtesy. All balances are ultimately the patient's responsibility and any charges not covered or paid by insurance coverage shall be due and payable by the patient.

We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.

Special Charges:
Returned checks are subject to a 'returned check' fee. All outstanding balances, over 30 days, will be subject to a monthly late fee. We reserve the right to charge a fee for missed appointments, unless we are notified twenty four hours in advance of the scheduled appointment.

Patient Agreement
I have read, understood, agreed to, and received a copy of this agreement.

Questions
Please ask if you have any questions about this agreement or if your ability to comply with its provision changes. We are here to help.

_____ _____ _____ _____
Patient/Responsible Party Signature *Date* *Office Representative* *Date*

Pt#_____

PATIENT INFORMATION

Patient's Name:_____

Address:_____City:_____State:_____Zip:_____

Home/Cell Phone:_____Work Phone: _____

Email address: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits to be paid directly to Dr. Marjorie Brockman. I understand I am financially responsible for any amount not covered by this authorization.

Primary Insurance: _____

Policy holders name:_____Birthdate: _____

Policy number: _____

Patient/Guardian initials: _____

INFORMATION RELEASE

I hereby authorize Dr. Marjorie Brockman, to release any medical information to the insurance carrier/agent or medical personnel. I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history to Dr. Marjorie Brockman. I approve my records being sent by fax, if necessary.

Patient/Guardian initials: _____

AUTHORIZATION FOR TREATMENT

I authorize Dr. Marjorie Brockman to perform chiropractic care and adjunctive therapies to above named patient.

Patient/Guardian signature:_____Date: _____

CONFIDENTIAL MEDICAL HISTORY

Name_____ **Date**_____

List surgical operations and year of each

_____

List accidents and year (auto and other)_____

Many health problems are the result of heredity. Information about your family members will give me a better picture of your total health

Relationship	**His or her past and present health problems**

Do you smoke?_____ **How much?**_____ **Do you use alcohol?** _____ **How much?**_____

Please mark any of the following symptoms which you now have or have had within the last 6 months:

GENERAL
Allergy
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Headache
Loss of sleep
Loss of weight
Nervousness
Depression
Numbness
Sweats
Tremors

MUSCLE & JOINT
Arthritis
Bursitis
Hernia
Low back pain
--Pain or numbness in:
Shoulders
Arms
Elbows
Hands
Hips
Legs
Knees
Feet

GASTRO-INTESTINAL
Belching or gas
Colitis
Colon trouble
Constipation
Diarrhea
Difficult digest
Distended abdomen
Excessive hunger
Gall bladder
Hemorrhoids
Jaundice
Liver trouble
Nausea
Pain over stomach
Poor appetite
Vomiting
Vomiting blood

EYES, EARS, NOSE, & THROAT
Asthma
Colds
Deafness
Earache
Ear discharge
Ear noises
Enlarged glands
Enlarged thyroid
Eye pain
Failing vision
Hay fever
Nasal obstruction
Nosebleeds
Sinus infection
Sore throat
Tonsilitis

CARDIO-VASCULAR
Hardening arteries
High blood pressure
Low blood pressure
Pain over heart
Poor circulation
Rapid heart beat
Slow heart beat
Swelling of ankles

RESPIRATORY
Chest pain
Chronic cough
Difficult breath
Spitting up blood
Wheezing

SKIN
Boils
Bruises easily
Dryness
Hives or allergy
Itching
Skin rash
Varicose veins

GENITO-URINARY
Bed wetting
Blood/pus in urine
Frequent urination
Bladder infection
Kidney stones
Painful urination
Prostate trouble

FEMALE
Congested breasts
Cramps or backache
Excessive Flow
Hot flashes
Irregular cycle
Menopausal symptoms
Painful discharge
Vaginal discharge
Pregnant?
Yes No

Date of last period
_____

CONDITIONS YOU HAVE HAD:
AIDS/HIV positive
Alcoholism
Anemia
Appendicitis
Arteriosclerosis
Arthritis
Cancer
Chorea
Cold Sores
Diabetes
Diphtheria
Eczema
Emphysema
Epilepsy
Fever blisters
Goiter
Gout
Heart Disease
Hepatitis
Influenza
Lupus
Malaria
Measles
Miscarriage
Multiple sclerosis
Mumps
Pleurisy
Pneumonia
Polio
Rheumatic fever
Scarlet fever
Stroke
Tuberculosis
Typhoid fever
Ulcers
Venereal disease
Whooping cough
Other

Signature:_____

CHIEF COMPLAINT

Chart #_____

Name_____ Date_____

Location and brief description of your chief complaint_____
_____

Approximately when did your problem start? DATE_____

What caused or contributed to the onset?_____

How did your problem begin **GRADUALLY** or **SUDDENLY**?

Describe the sensation you feel. **DULL SHARP BURNING ACHING TINGLING THROBBING STABBING NUMBNESS OTHER**_____

Does it radiate to any other part of your body? **YES NO**

Where would you rate the severity of your pain on a scale of 0 to 10, with 0 being no pain, and 10 being the worst pain you can imagine? **0 1 2 3 4 5 6 7 8 9 10**

Is your pain **CONSTANT, FREQUENT, OCCASIONAL** or **INTERMITTENT?**

Is your condition getting **BETTER** or **WORSE** or staying the **SAME**?

What makes it better? **REST TIME-OF-DAY POSITIONS HEAT ICE NOTHING OTHER**_____

What makes it worse? **POSITIONS COUGHING SNEEZING STRAINING BOWEL MOVEMENTS NOTHING OTHER**_____

Does the pain or problem change with time of day or month? **YES NO**
Has there been any change in you bodily functions? **YES NO**
URINATION DEFECATION RESPIRATION DIGESTION VISION SEXUAL OTHER_____
Has your condition affected your daily activities? **YES NO**
Have you ever had anything like this before? **YES NO**
Are you currently taking any medication? **YES NO**
Have you sought other professional care for this condition? **YES NO**
Have you had any recent illnesses? **YES NO**
Have you ever had chiropractic care before? **YES NO**

Patient or guardian's signature_____

Brockman Family Chiropractic 445 Idaho Street Gooding, Idaho 83330 Ph: (208) 934-5000