DELMARVA CHIROPRACTIC
AND WELLNESS CENTER

203 Shaw Ave.
Harrington, DE 19952
Phone: 302-682-7975
Fax: 302-566-6046
www.delmarvawellness.com

PLEASE FILL OUT ALL FIELDS ON ALL PAGES

Todays Date: _____/_____/_____ **Patient Birthday:**_____/_____/_____

First Name: _____ **Middle Name:**_____ **Last Name:** _____

Married: (Circle) Yes No **Spouse Name:**_____ **# of Children:** _____

Home #: _____ **Cell #:**_____ **Work #:** _____

Address: _____

City:_____ **State:**_____ **Zip:**_____

Emergency Contact:_____ **Emergency Relation:**_____ **Emergency Phone:** _____

Patient Email: _____

Employed at:_____ **Occupation:**_____

Employer Address:_____

Work Duties: _____

May we **contact you** regarding your care at this office and/or **your health records**? **Yes** **No**
Can we **leave a message** on the phone numbers listed above? **Yes** **No**

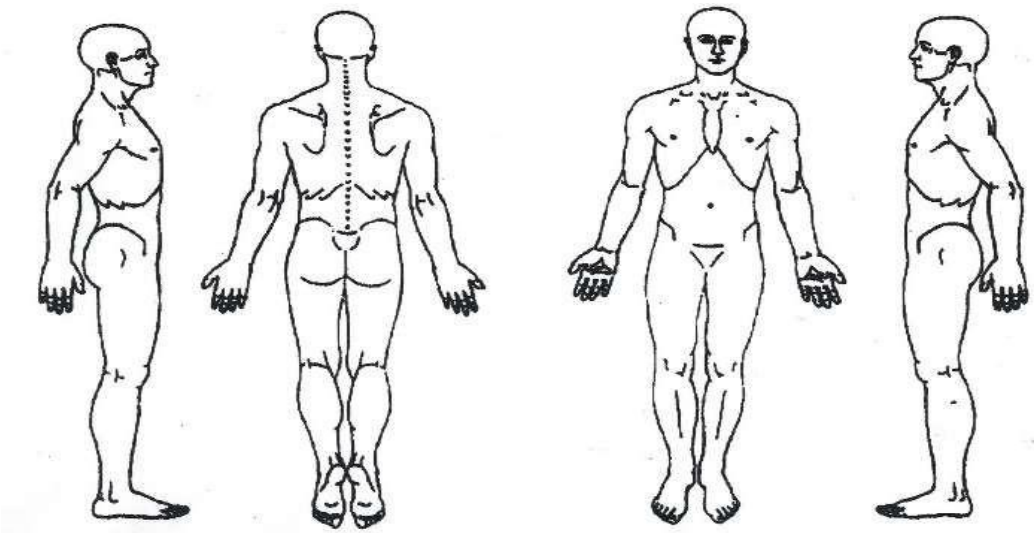
CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaska Native **/** Asian **/** Black or African American **/** White (Caucasian) **/** Native Hawaiian orPacific islander **/** I Decline to Answer

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

How did you hear about us:_____

Please circle area of primary complaint <u>BELOW</u>:



Briefly describe your pain. (sharp, shooting, etc.)

_____

_____

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Medical History

Name: _____ DOB: _____

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Previous Chiro Care: (Circle)	**Yes**	**No**	Date: _____		Explain: _____	
Surgery: (Circle)	**Yes**	**No**	Explain: _____			
Hospitalized: (Circle)	**Yes**	**No**	Explain: _____			
Chance Pregnant: (Circle)	**Yes**	**No**	Planning: (Circle):	**Yes**	**No**	
Auto Accident (Circle):	**Yes**	**No**	Treatment (Circle):	**Yes**	**No**	Explain: _____
Other Previous Trauma/Injury (Circle):	**Yes**	**No**	Treatment (Circle):	**Yes**	**No**	Explain: _____
Struck Unconscious (Circle):	**Yes**	**No**	Treatment (Circle):	**Yes**	**No**	Explain: _____
Stroke: (Circle)	**Yes**	**No**	Explain: _____			

Please list any medical conditions, including any prescribed medications.

Medical Conditions (Please List All)	Medication	Dosage and Frequency (i.e. 5mg daily)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

Family Health History:	**MEDICAL CONDITION(S)**	**LIVING Y/N**
Mother:		
Father:		
Sibling(s)		
Children:		

Smoking: Daily Weekly Occasion Never Former **Vape:** YES NO

Alcohol: Daily Weekly Occasion Never **Caffeine:** Daily Weekly Occasion Never

Recreational Drugs: Daily Weekly Occasion Never **Exercise:** Daily Weekly Occasion Never

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Health Checklist (Please check all that apply)

Name:_____DOB:_____

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Bruise Easily	☐ Breast Lump	☐ Bronchitis
☐ Cold Extremities	☐ Cancer	☐ Chest Pain
☐ Cramps	☐ Depression	☐ Diabetes
☐ Digestion Problems	☐ Dizziness	☐ Eye Pain or Difficulties/Vision Disturbance
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ High Blood Pressure	☐ Hot Flashes	☐ Insomnia
☐ Irregular Heartbeat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Balance	☐ Loss of Smell
☐ Loss of Taste	☐ Metal Implants	☐ Nosebleeds
☐ Pacemaker	☐ Prostate Trouble	☐ Sciatica
☐ Shortness of Breath	☐ Spinal Curvatures	☐ Stroke
☐ Swelling of Ankles	☐ Swollen Joints	☐ Thyroid Condition
☐ Tuberculosis	☐ Ulcers	

Primary Care Physician Communication

We will communicate with your Primary Care Physician listed on the previous form by sending your initial exam, periodical exams, and clinical notes. **Dr Riggin recommends communication with your Primary Care Physician if possible.**

Communication Options (Please Check One)

- ☐ **Yes,** please communicate with my physician
- ☐ **No,** I would like to **opt out** of communicating with my physician
- ☐ I do not have a Primary Care Physician

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we strongly urge you to call 24 hours prior to cancelling your appointment. After 2 missed appointments within 30 days, we reserve the right to assess a $20 charge. If a $20 charge is implemented and you miss or cancel an appointment for a third time we will not reschedule you until we have received all due fees and charges in full amount. If you miss your new patient appointment then we will not reschedule you for 90 days after that appointment. To avoid any missed appointments, our office will text/email you to confirm your appointment.

- ☐ **I would like to get appointment reminders by TEXT**
- ☐ **I would like reminders sent to my EMAIL**

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Statement of Patient Financial Responsibility

As an elective participant in our chiropractic services, you are ultimately responsible for the payment of your bill in full. You are responsible for payment of any deductible and co-pay/co-insurance as determined by your insurance carrier. We expect any billed balances within 30 days of patient bill being received. If your insurance denies any part of your claim, or if you elect to continue past your approved period, you will be responsible for your balance in full.

I agree to the above mentioned financial responsibility and cancellation policies:

Patient/Guardian Signature: _____

Date:_____

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Informed Consent to Chiropractic Adjustments and Care

I consent to the performance of chiropractic adjustments and other chiropractic procedures on me including various modes of physical therapy or diagnostic x-rays by Dr. Jesse Riggin and/or other licensedDoctor of Chiropractic employed at this practice.
I understand that there are some risks to chiropractic treatment including, but not limited to, fractures,discs injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate all possible risks and complications, however I wish to rely on the doctor to act in my best interests based upon the facts known.
I have read, or have had read to me, the above consent. I have had the opportunity to discuss with Dr. Riggin the nature and purpose of chiropractic procedures as well as the associated risks. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course oftreatment for my present condition and for any future conditions for which I seek treatment.

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

I hereby acknowledge that I have received a current copy of Delmarva Chiropractic and Wellness Center's "Notice of Privacy Practices" **(available upon request)**. A representative of DCWC has explained the "Notice of Privacy Practices" to my satisfaction. I am aware that DCWC has included a provision that it reserves the right to change the terms of its notice. I have read the Privacy Notice (Ref. form 2016.7.19) and understand my rights contained in the notice. By way of my signature, I provide DCWC with my authorization and consent to disclose my protected healthcare information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

HIPPA Requests *(You Must Check One)*

- ☐ *I wish to file a **"Request for Restriction"** of my Protected Health Information.*
- ☐ *I wish to file a **"Request for Alternative Communications"** of my Protected Health Information.*
- ☐ *I wish to object to the following in the **"Notice of Privacy Practices".***
- ☐ ***I agree with the current policy.***

I have read and agree to the "Informed Consent to Chiropractic Adjustments and Care" as well as the "Acknowledgment of Receipt of HIPPA Notice of Privacy Practices". I certify that I am the patient or legal guardian listed below and that the included information is true and accurate to the best of my knowledge.

******If the patient is under the age of 18, a parent must sign this form and be present for the initial appointment.***

*****Parent Name (Printed): _____**

Patient Name: _____

Patient/Guardian Signature: _____

Date:____/____/_____