Terry H Martin, D.C.

Patient Information

PERSONAL INFORMATION

NAME:_____

HOME PHONE:_____ **CELL PHONE**:_____ **E-MAIL**: _____

ADDRESS:_____ **CITY**:_____ **STATE**:_____ **ZIPCODE**:_____

SEX: **MALE** _____ **FEMALE**_____ **AGE:**_____ **BIRTHDATE:**_____

SINGLE ____ **MARRIED** ____ **WIDOWED** ____ **DIVORCED** ____ **SPOUSE'S NAME:**_____

PATIENT'S SS# :_____ **DRIVERS LICENSE:**_____

EMERGENCY CONTACT: NAME:_____ **PHONE#:**_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: _____

EMPLOYMENT

OCCUPATION: _____

EMPLOYER:_____

EMPLOYER ADDRESS:_____ **CITY**:_____ **STATE**:_____ **ZIPCODE**:_____

WORK PHONE:_____ **WORK E-MAIL**:_____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

We need your assistance and your understanding of our payment and insurance submittal policy. As a service and convenience to you, we will file insurance claims for you. **Your insurance coverage is a contract between you, your employer, and your insurance company.** We are not a party to this contract. Our relationship is with you and not your insurance company. All charges are your responsibility. It is your responsibility to confirm the doctor is on your insurance provider list. It is your responsibility to secure adequate referral forms if necessary.

Our office will bill your first insurance as a courtesy to you. We will bill your second insurance if you contact us after your first insurance has paid. We require all co-payments to be made at the time of service. **We have no control over what your insurance company will or will not pay.** We have found that some insurance companies do not cover all the medical/chiropractic services we render; we will try to code our services for the insurance companies allowed coverage. It is against the law for us to adhere to a policy of "no out of pocket expense". **Upon receipt of payment from your insurance company, we will bill you for the outstanding balance unless financial arrangements have been made.** If you do not have insurance we will be happy to make financial arrangements for the total amount of your billing. Please seek that arrangement before services are rendered.

I authorize and direct my Insurance Company to pay Terry H Martin, D.C. directly any benefits I may have for services rendered.

I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of service.

In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 50 percent of my unpaid balance; in addition to my balance, in the event that my account is delinquent.

In the event that it is necessary to commence legal action to collect this bill, I agree to pay responsible attorney's fees and cost of court and agree to submit to the jurisdiction of the Circuit Court, SLC, SL Co., Utah. If any portions of this bill or the provider's services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs of doing so.

I have read, understand, and agree to the policy above.

NAME: (PRINT): _____ **SIGNATURE:** _____ **DATE:** _____

Parent—if patient is under 18 years of age.

DESCRIBE MAIN COMPLAINT: _____

OTHER COMPLAINTS:_____

DATE OF ONSET:_____THIS RESULTED FROM: ACCIDENT _____ ILLNESS _____UNKNOWN _____

DESCRIBE ACCIDENT OR ONSET:_____

HAVE YOU BEEN HURT IN THIS AREA BEFORE? YES_____ NO_____ IF SO, DATES _____

WHAT AGGRAVATES THIS CONDITION_____

OTHER DOCTORS WHO HAVE TREATED THIS CONDITION_____

DATE OF LAST PHYSICAL EXAM:_____DESCRIBE_____

LIST SURGICAL OPERATIONS & DATES_____

MEDICATIONS YOU ARE CURRENTLY TAKING_____

_____

Please **CIRCLE** any condition or symptom that you are now experiencing & **UNDERLINE** any which you have previously had.

MUSCULOSKELETAL

Low back problems
Pain between shoulders
Neck problems
Arm problems
Leg problems
Painful joints
Stiff joints
Sore muscles
Weak muscles
Walking problems
Ruptures
Broken bones

NUTRITIONAL

Vitamin Supplements
_____
_____
____Meals per day
____% Protein
____Sweets per day

NERVOUS

Numbness
Burning
Paralysis
Loss of feeling
Dizziness
Fainting
Headaches
Muscle jerking
Convulsions
Forgetfulness
Confusion
Depression

GENITO-URINARY SYSTEM

Bladder infection
Excessive urine
Scanty urination
Painful urination
Discolored urine
Nocturnal urination
Hernia
Genital sores
Urethral discharge

CARDIOVASCULAR

Chest pain
Rheumatic fever
Pain over heart
Heart disease
Difficult breathing
Persistent cough
Coughing phlegm
Coughing blood
Rapid heartbeat
Blood pressure
Heart problems
Lung problems
Varicose veins
Last EKG _____
Date last X-ray_____

FEMALE

Vaginal discharge
Vaginal bleeding
Vaginal pain
Breast pain
Lumps on breast
Heat changes
Last breast exam ___
Last period_____

EYE, EAR, NOSE, THRO

Eye strain
Eye inflammation
Vision problems
Ear pain
Ear noises
Hearing loss
Ear discharge
Nose pain
Nose bleeding
Nose discharge
Nose breathing/difficul
Sore gums
Dental problems
Sore mouth
Sore throat
Hoarseness
Difficult speech
Allergies

GASTRO-INTESTINAL

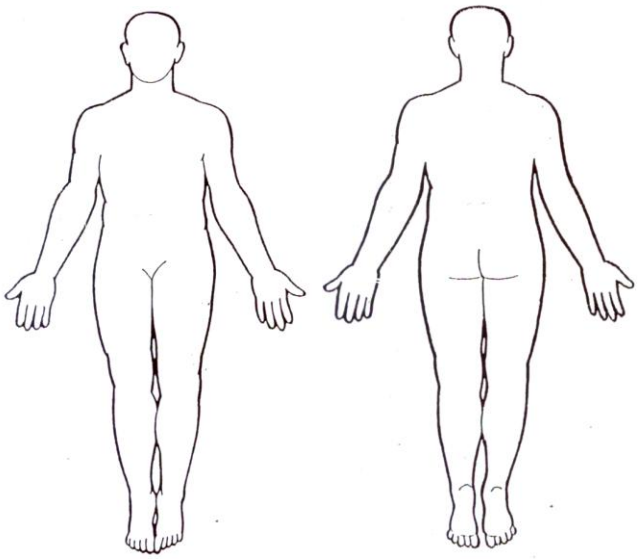
Poor appetite
Excessive hunger
Difficult chewing
Difficulty swallowing
Excessive thirst
Nausea
Heartburn, indigestior
Vomiting food
Vomiting blood
Abdominal pain
Diarrhea
Constipation
Black stools
Bloody stools
Hemorrhoids
Liver problems
Gall Bladder problems
Weight problems

NAME_____ DATE _____

DRAW THE LOCATION OF YOUR PAIN ON THE BODY OUTLINES

ACHE	**BURNING**	**NUMBNESS**	**PINS & NEEDLES**	**STABBING**	**OTHER**
AAAAAA	= = = = = =	OOOO	. . . . .	/ / / / / /	X X X X X

FRONT BACK



INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference.

EXAMPLE:

HEADACHE NECK LOW BACK

NO PAIN ---------- **WORST POSSIBLE PAIN**

0 [1] 2 3 [4] 5 6 7 8 9 [10]

1. What is your pain **RIGHT NOW**?

NO PAIN ---------- **WORST POSSIBLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

NO PAIN ---------- **WORST POSSIBLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

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

NO PAIN ---------- **WORST POSSIBLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

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

4. What is your pain level **AT ITS WORST** (how close to "10" does your pain get at its worst)?

NO PAIN ---------- **WORST POSSIBLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

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

NAME_____ AGE _____ DATE _____

Terry H Martin, D.C.
1951 West 4700 South, Suite 1
Taylorsville, Utah 84129

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION
OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your healthcare information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.
- We may have you disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your personal information to remind you of your appointment.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practice as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions, however, if we agree with your restrictions, the restriction is binding upon us.

Your right to revoke your authorization

You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____
PRINT NAME AUTHORIZED PROVIDER REPRESENTATIVE

_____ _____
SIGNATURE DATE

_____
DATE