



## North Texas Performance Chiropractic – New Patient Form

1304 Village Creek Dr., Suite 300 · Plano, TX · 75093 · office 972-250-0300 · fax 972-248-0840

### PATIENT INFORMATION

Date

Patient

Address

City

State  Zip  SS#

Sex:  M  F Age  Birthdate

Marital Status  Occupation

### EMPLOYER'S INFORMATION

Employer

Address

City

State  Zip  Phone

### SPOUSE'S INFORMATION

Name

Birthdate  SS#

Occupation

Spouse's Employer

Whom may we thank for referring you?

### INSURANCE

Who is responsible for this account?

Relationship to Patient

Insurance Co.

ID#  Group #

Is patient covered by additional insurance?  Yes  No

Subscriber's Name

Relationship to Patient

SS#  Birthdate

Insurance Co.

ID  Group #

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with  and assign directly to Dr. Tribendis all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**PHONE NUMBERS**

Home  Cell   
 Work  Ext.   
 E-mail

**IN CASE OF EMERGENCY, CONTACT:**

Name   
 Relationship   
 Home  Work/Cell

**ACCIDENT INFORMATION**

Is condition due to an accident?  Yes  No Date

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney's Name (if applicable)

**PATIENT CONDITION**

Reason for visit  When did your symptoms appear?

Is condition getting worse?  Yes  No  Unknown How often is this pain?

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)  Mark where you have pain.

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
(check all that apply)  Burning  Tingling  Cramps  Stiffness  Swelling  Other

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down

**HEALTH HISTORY**

**What treatment have you already received for your condition?**

Medications  Surgery  Physical Therapy  Chiropractic Services  None  Other

Name and address of other doctor(s) who have treated your condition.

Date of Last: Physical Exam  Spinal X-Ray  Blood Test  Spinal Exam

Chest X-Ray  Urine Test  Dental X-Ray  MRI, CT-Scan, Bone Scan

Place a check mark on "Yes" or "No" to indicate if you had any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No <b>AIDS/HIV</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Alcoholism</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Allergy</b> <b>Shots</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Anemia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Anorexia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Appendicitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Arthritis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Asthma</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Bleeding</b> <b>Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Breast</b> <b>Lump</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Bronchitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cancer</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cataracts</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Chemical</b> <b>Dependency</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Chicken Pox</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Diabetes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Emphysema</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Epilepsy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fractures</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Glaucoma</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Goiter</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Gonorrhea</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Gout</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Heart</b> <b>Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hepatitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hernia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Herniated</b> <b>Disk</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Herpes</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>High</b> <b>Cholesterol</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Kidney</b> <b>Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Liver</b> <b>Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Measles</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Migraine</b> <b>Headaches</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Miscarriage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Mononucleosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Multiple</b> <b>Sclerosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Mumps</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Osteoporosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Pacemaker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Parkinson's</b> <b>Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Pinched</b> <b>Nerve</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Pneumonia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Polio</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Prostate</b> <b>Problem</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Prosthesis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Psychiatric</b> <b>Care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Rheumatoid</b> <b>Arthritis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Rheumatic</b> <b>Fever</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Scarlet Fever</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Stroke</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Suicide Attempt</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Thyroid Problems</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tonsillitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tuberculosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tumors, Growths</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Typhoid Fever</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Ulcers</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Vaginal Infections</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Whooping Cough</b>  <input type="text"/> Other <input type="text"/> Other <input type="text"/> Other <input type="text"/> Other
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<p><b>Are you pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Due Date <input type="text"/></p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><b>EXERCISE</b></td> <td style="width: 50%;"><b>WORK ACTIVITY</b></td> </tr> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> Sitting</td> </tr> <tr> <td><input type="checkbox"/> Moderate</td> <td><input type="checkbox"/> Standing</td> </tr> <tr> <td><input type="checkbox"/> Daily</td> <td><input type="checkbox"/> Light Labor</td> </tr> <tr> <td><input type="checkbox"/> Heavy</td> <td><input type="checkbox"/> Heavy Labor</td> </tr> </table>	<b>EXERCISE</b>	<b>WORK ACTIVITY</b>	<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <p><input type="checkbox"/> Smoking <input type="text"/> Packs/Day</p> <p><input type="checkbox"/> Alcohol <input type="text"/> Drinks/Week</p> <p><input type="checkbox"/> Coffee/Caffeine Drinks <input type="text"/> Cups/Day</p> <p><input type="checkbox"/> High Stress ~ Give Reason <input type="text"/></p>	<p><b>Describe the Injuries/Surgeries you had</b></p> <p><input type="text"/> Falls <input type="text"/> Date</p> <p><input type="text"/> Head Injuries <input type="text"/> Date</p> <p><input type="text"/> Broken Bones <input type="text"/> Date</p> <p><input type="text"/> Dislocations <input type="text"/> Date</p> <p><input type="text"/> Surgeries <input type="text"/> Date</p> <p><input type="text"/> Surgeries <input type="text"/> Date</p>
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**MEDICATIONS**

**ALLERGIES**

**VITAMINS/HERBS/MINERALS**

Pharmacy Name

Pharmacy Phone



I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



## **HIPAA Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MUCH MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health office care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for 'other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



**Your Rights** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail or any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy content of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 4, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice or our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice or our Privacy Practices:

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_