



Mr. \ Mrs. \ Ms. \ Miss

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Page | 1

What Do You Prefer To Be Called: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS #: \_\_\_\_\_ Sex: \_\_\_\_\_ Single \ Married \ Divorced \ Widow

Spouse Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ T: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Who can we thank for the referral? \_\_\_\_\_

Who is your Primary Care Doctor? \_\_\_\_\_

Do you have Medicare?  Yes  No

Secondary Insurance or Supplement to Medicare: \_\_\_\_\_

Primary Insurance (Besides Medicare): \_\_\_\_\_

---

– Please hand the front desk all of your insurance cards –  
– They will copy them & return back to you –

---



Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Glover Chiropractic Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature                                  Date                                  Parent (if patient is a minor)

<b>The US Government is now requiring that we supply them with the following information:</b>
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian/Pacific Islander
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Mandarin <input type="checkbox"/> Cantonese <input type="checkbox"/> Tagalog <input type="checkbox"/> Japanese
Have you ever been diagnosed with either of the following? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes





Please list any surgical procedures you have had: \_\_\_\_\_

---

Page | 4

Do you have any allergies to medication/food/seasonal?

No  Yes, Please list: \_\_\_\_\_

What activities do you do during the day?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day

Please list any hobbies or activities you do outside of work: \_\_\_\_\_

---

Any other hospitalizations not previously mentioned?

No  Yes, Please list: \_\_\_\_\_

Any other past significant trauma?

No  Yes, Please list: \_\_\_\_\_



Please circle any of the following symptoms you have had or Check NONE

		NONE
<b>CONST</b>	FEVER CHILLS WEIGHT LOSS WEIGHT GAIN	
<b>EYES</b>	GLASSES CONTACTS VISION CHANGES	
<b>EARS</b>	HEARING AIDS DIFFICULT HEARING LOSS OF HEARING	
<b>NOSE</b>	SINUS PAIN	
<b>THROAT</b>	DIFF. SWALLOWING SORE THROAT	
<b>MOUTH</b>	MOUTH PAIN	
<b>CARDIO</b>	CHEST PAIN PALPITATIONS	
<b>RESP</b>	SHORTNESS OF BREATH COUGH	
<b>GI</b>	ABD PAIN NAUSEA VOMITTING DIARRHEA CONSTIPATION ACID REFLUX	
<b>GU</b>	CHANGE IN FREQUENCY OR PAIN WITH URINATION	
<b>SKIN</b>	RASH WOUNDS	
<b>NEURO</b>	SEIZURE FAINTING NUMBNESS TINGLING WEAKNESS DIZZINESS	
<b>H</b>	DEPRESSION CHANGE IN APPETITE CHANGE OF SLEEP	
<b>ENDOCRINE</b>	DRY SKIN	

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



## INFORMED CONSENT

Page | 6

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr. Jeffrey N. Glover will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr. Jeffrey N. Glover. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

_____ PRINT PATIENT NAME	_____ SIGNATURE	_____ DATE
-----------------------------	--------------------	---------------

If patient is a minor:

_____ PRINT PARENT/GUARDIAN NAME	_____ SIGNATURE	_____ DATE
-------------------------------------	--------------------	---------------



## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Page | 7

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Patient's legal representative (please print)

\_\_\_\_\_  
Signature

List below the names and relationship of people to whom you authorize Glover Chiropractic Clinic to release PHI.

_____	_____
_____	_____
_____	_____