ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
WOULD YOU LIKE TEXT MESSAGE REMINDERS? CIRCLE Y or N CELL PHONE PROVIDER:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY #:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	EMPLOYER ADDRESS:
WORK PHONE:	POSITION TITLE:

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE OR HAVE YOU EVER SMOKED?	☐ YES	☐ NO
DO YOU DRINK ALCOHOL?	☐ YES	☐ NO
DO YOU DRINK COFFEE, TEA OR SODA?	☐ YES	☐ NO
DO YOU EXERCISE REGULARLY?	☐ YES	☐ NO

DO YOU WEAR:

☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS

MEDICATIONS YOU TAKE

☐ CHOLESTEROL MEDICATIONS	☐ INSULIN
☐ STIMULANTS	☐ PAIN KILLERS
☐ TRANQUILIZERS	☐ BLOOD PRESSURE MEDICINE
☐ MUSCLE RELAXORS	☐ OTHER

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): ☐ NEWSPAPER ☐ SIGN ☐ YELLOW PAGES ☐ COMMUNITY EVENT ☐ MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. I F YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE: ☐ WELLNESS ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY ☐ JOB ☐ CHRONIC DISCOMFORT ☐ OTHER PLEASE EXPLAIN:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: ☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GONE
DOES THIS CONCERN INTERFERE WITH: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? ☐ YES ☐ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ☐ YES ☐ NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: ☐ GOOD ☐ BAD ☐ INDIFFERENT

SUPPLEMENTS YOU TAKE

☐ ESSENTIAL FATTY ACIDS	☐ PROBIOTIC
☐ MULTIVITAMIN WHICH :_____	☐ OTHER_____
☐ CALCIUM / MAGNESIUM	☐ OTHER _____
☐ VITAMIN C	☐ OTHER _____

Bubanic Chiropractic Inc.

4082 Fulton Dr NW
Canton, OH 44718
O: (330) 491-8100 F (330) 491-8147
www.bubanicchiropractic.com

FOR WOMEN ONLY

ARE YOU PREGNANT?	☐YES	☐NO	☐ UNSURE
IF YES, WHEN IS YOUR DUE DATE?			
ARE YOU NURSING?	☐YES	☐NO	
ARE YOU TAKING BIRTH CONTROL?	☐YES	☐NO	
DO YOU:			
EXPERIENCE PAINFUL PERIODS?	☐YES	☐NO	
HAVE IRREGULAR CYCLES?	☐YES	☐NO	
HAVE BREAST IMPLANTS?	☐YES	☐NO	

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Relief care:** Symptomatic relief of pain or discomfort.
- ☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ☐ ***I want the Doctor to select the type of care appropriate for my condition.***

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ☐YES ☐NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ☐YES ☐NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ☐YES ☐NO

YOUR CONCERNS

Please circle any of the following that you may be experiencing: :

Sore Throat ☐
Stiff Neck ☐
Radiating Arm Pain ☐
Hand/Finger Numbness ☐
Asthma ☐
Allergies ☐
High Blood Pressure ☐
Heart Conditions ☐

Constipation ☐
Colitis ☐
Diarrhea ☐
Gas Pain ☐
Irritable Bowel ☐
Bladder Problems ☐
Menstrual Problems ☐
Low Back Pain ☐
Pain or Numbness in legs ☐
Reproductive Problems ☐

Headaches ☐
Migraines ☐
Dizziness ☐
Sinus Problems ☐
Allergies ☐
Fatigue ☐
Head Colds ☐
Vision Problems ☐
Difficulty Concentrating ☐
Hearing Problems ☐

Middle Back Pain ☐
Congestion ☐
Difficulty Breathing ☐
Bronchitis ☐
Pneumonia ☐
Gallbladder Conditions ☐
Stomach Problems ☐
Ulcers ☐
Gastritis ☐
Kidney Problems ☐

OTHER:

_____

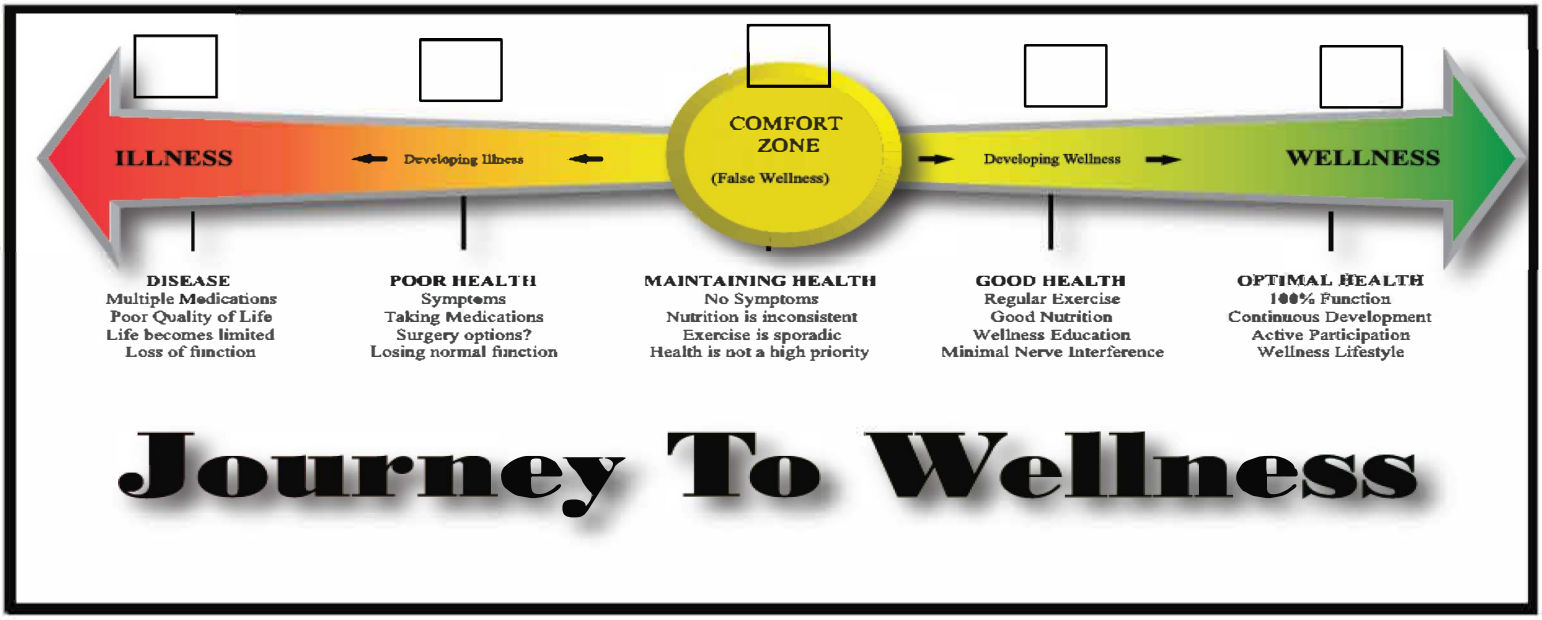
_____

_____

Bubanic Chiropractic Inc.

Rate your health

Place an '**X**' that denotes where you believe your current level of health to be.
Place an '**O**' indicating where you would like your health to be.



HEALTH INSURANCE INFORMATION

Name of Your Health Insurance Co._____

Policy #_____ Group #_____

Insured's Name if different than yours_____ Insured's SS#_____/_____/_____

Relationship to Insured_____ Insured's Birth Date_____/_____/_____

Employer_____

SECONDARY INSURANCE INFORMATION

Name of Your Health Insurance Co._____

Policy #_____ Group #_____

Insured's Name if different than yours_____ Insured's SS#_____/_____/_____

Relationship to Insured_____ Insured's Birth Date_____/_____/_____

Employer_____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself If this office chooses to bill any services to my insurance carrier, that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor_____Date_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

***Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

INITIAL IF READ ABOVE_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- *You may request restrictions on your disclosures .*
- *You may inspect and receive copies of your records within 30 days with a request.*
- *You may request to view changes to your records .*
- *In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly .*
- *Obtain payment from third party payers .*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications .*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

PATIENTS UNDER THE AGE OF 18:

AUTHORIZATION FOR CARE OF A MINOR

Bernard Bubanic, DACBSP has my permission to treat my minor child_____ in my absence.

Persons who I consent to bringing them are:_____

PARENT OR GUARDIAN AUTHORIZATION CARE SIGNATURE:	DATE:

Bubanic Chiropractic Inc.

4082 Fulton Dr NW
Canton, OH 44718
O: (330) 491-8100 F (330) 491-8147
www.bubanicchiropractic.com

INFORMED CONSENT

Date: _____ Patient Name: _____ DOB: _____

Account #: _____ Physician: _____

I voluntarily consent to medical care, which may include routine office visits, diagnostic procedures and other therapeutic interventions and medical treatment by my physician, his / her assistants, or his / her designees, as is necessary in his / her judgment. Medical care may also be provided by a Nurse Practitioner, technicians, therapists and other providers which are supervised by qualified physicians. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services, procedures, treatments or examinations at Bubanic Chiropractic Inc.

This consent is designed to cover all procedures at Bubanic Chiropractic Inc, which do not require an additional "Special Consent Form."

It is anticipated that I (the patient) will require a series of services and this Consent to Treat shall cover all services while I am a patient of Bubanic Chiropractic Inc.

Patient / Representative Initials: _____

I, _____ **have read this form and I fully understand and accept**
(Patient / Patient Representative)
its terms and conditions.

Patient / Representative Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Bubanic Chiropractic Inc.

4082 Fulton Dr NW
Canton, OH 44718
O: (330) 491-8100 F (330) 491-8147
www.bubanicchiropractic.com