

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_



## DEMOGRAPHIC FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex:  M  F Marital Status:  Single  Married  Widower  Divorced

Race:  African American  Caucasian Ethnicity:  Latin/ Hispanic/ Spanish  Non-Latin/Hispanic/Spanish  Asian

Language:  English  Spanish  Other: \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### GUARANTOR/PARENT/ RESPONSIBLE PARTY INFORMATION

Responsible Party Name: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security No: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Cell Phone \_\_\_\_\_

**IS THIS INJURY WORK RELATED?** Yes / No

(If yes, please fill out the following)

Workers' Comp Name: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Case #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you Currently Working: No / Part Time with Restrictions / Full Time Regular Duties

Preferred Pharmacy: \_\_\_\_\_

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Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1) What is your MAIN reason for your visit today? \_\_\_\_\_

<b>Neck</b>	<b>Shoulder</b>	<b>Elbow</b>	<b>Pelvis</b>	<b>Knee</b>	<b>Ankle</b>	<b>Foot</b>
Radiates ___ R Arm	___ Right	___ Right	___ Right	___ Right	___ Right	___ Right
Radiates ___ L Arm	___ Left	___ Left	___ Left	___ Left	___ Left	___ Left
<b>Back</b>	<b>Arm</b>	<b>Wrist</b>	<b>Hip</b>	<b>Hand</b>	<b>Fingers</b>	<b>Toes</b>
Radiates ___ R Leg	___ Right	___ Right	___ Right	___ Right	___ Right	___ Right
Radiates ___ L Leg	___ Left	___ Left	___ Left	___ Left	___ Left	___ Left

2) How long has the problem been present?  
\_\_\_\_\_

3) Did an injury event take place?  Work Injury  Motor Vehicle Accident  Fall  Sports Injury  
 Other: \_\_\_\_\_  Cannot Identify

4) Severity of Pain?      0 1 2 (mild) 3 4 5 (moderate) 6 7 8 (severe) 9 10 (extremely severe)

5) Quality of Pain?  Aching  Burning  Gnawing  Stabbing  Throbbing  Sharp  Dull  
 Superficial  Deep  Occasional  Frequent  Constant

6) What activities make your symptoms worse?  Sitting  Standing  Lying Down  Walking  
 Lifting  Carrying  Twisting  Bending/Squatting  Pushing/Pulling  Gripping  Squeezing  
 Throwing  ROM  Exercise  Computer Use  Changing Clothes  Getting Out of Bed Going from Sit to Stand  
 Upstairs  Downstairs  Morning  Daytime  Nighttime  Cold Weather  Damp Weather  Other: \_\_\_\_\_

7) What have you tried to alleviate problem?  Sitting  Standing  Lying Down  Changing Positions  
 Heat  Ice  Rest  Elevation  Exercise  Stretching  Limit Weight Bearing  Therapy  
 Chiropractic Care  Over The Counter Medications  Narcotics  Other Medication: \_\_\_\_\_  
 Injections  Bracing  Splint  Sling  
 Other: \_\_\_\_\_

8) Was anything successful at alleviating the problem:  Sitting  Standing  Lying Down  
 Changing Positions  Heat  Ice  Rest  Elevation  Exercise  Stretching  Limit Weight Bearing  
 Therapy  Chiropractic Care  Over The Counter Medications  Narcotics  Other Medication  
 Injections  Bracing  Splint  Sling  
 Other: \_\_\_\_\_

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Please list any drug allergies: \_\_\_\_\_

**Please list all medications or attach medication list**

Name of Med	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1) **Do you have any medical problems?** If so, please check from the list below: Anemia  
Anxiety/Depression Arthritis Asthma Bleeding Disorder Blood Clot Blood Transfusion  
Cancer  
Coronary Artery Disease Diabetes Gout Heart Attack(MI) Hepatitis High Cholesterol  
Hypertension Kidney Disorder Pacemaker Pulmonary Embolism Stroke Ulcers  
Other: \_\_\_\_\_

2) **Have you ever had surgery?** Yes / No

If yes, please list surgery type and date: \_\_\_\_\_

3) **Have you previously had an injury to the affected body part you are being seen for today?** No / Yes

If yes, please explain: \_\_\_\_\_

4) **In the past 60 days, have you experienced any of the following symptoms:** heartburn  
nausea vomiting blood in stool excessive thirst heat or cold intolerance weight loss fever  
blurred vision  
double vision vision loss hearing loss hoarseness trouble swallowing chest pain  
palpitations chronic cough shortness of breath painful urination blood in urine

**If any of these have been marked, please explain:** \_\_\_\_\_

**Family History:**

**Have any of your direct relatives had any of the following? Please check all that apply and indicate whether it was your Mother (by circling M) or Father (by circling F)**

Anemia-M/F Anxiety/Depression-M/F Arthritis-M/F Asthma-M/F Bleeding Disorder-M/F  
Blood Clot-M/F Blood Transfusion-M/F Cancer-M/F Coronary Artery Disease-M/F Diabetes-M/F  
Gout-M/F Heart Attack(MI)-M/F Hepatitis-M/F High Cholesterol-M/F Hypertension-M/F  
Kidney Disorder-M/F Pacemaker-M/F Pulmonary Embolism-M/F Stroke-M/F Ulcers-M/F  
Other-M/F: \_\_\_\_\_

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**Have any of your direct relatives had any of the following? Please check all that apply and indicate whether it was your Brother (by circling B) or Sister (by circling S).**

- Anemia-B/S    Anxiety/Depression-B/S    Arthritis-B/S    Asthma-B/S    Bleeding Disorder-B/S  
 Blood Clot-B/S    Blood Transfusion-B/S    Cancer-B/S    Coronary Artery Disease-B/S    Diabetes-B/S  
 Gout-B/S    Heart Attack(MI)-B/S    Hepatitis-B/S    High Cholesterol-B/S    Hypertension-B/S  
 Kidney Disorder-B/S    Pacemaker-B/S    Pulmonary Embolism-B/S    Stroke-B/S    Ulcers-B/S  
 Other-B/S: \_\_\_\_\_

**Social History:**

**Do you use tobacco products?**  No    Yes \*Packs per Day: \_\_\_\_\_ Years of Use: \_\_\_\_\_

**Do you use alcohol?**  Yes    No

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

Are you currently working? No / Part Time with Restriction / Full Time with Regular Duties

Patient Name: \_\_\_\_\_

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## HIPAA Notice of Privacy Practices

### **THIS NOTICE DESCRIBES HOW 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 care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **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 our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health 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 that 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 disclose your protected health information to medical school students that see patients at our office. In addition, 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 to remind 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 Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: 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.

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## HIPAA Notice of Privacy Practices

### 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, a 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 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 of 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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of 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 HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_



*Brian Kindl, MD*

**OFFICE POLICIES**

**APPOINTMENTS**

\_\_\_\_\_(Initial) I acknowledge that there is a \$40 fee for a missed appointment or late cancellation. The no show fee will be enforced if an appointment is not cancelled or rescheduled within 24 hours prior to the appointment time. The no show fee **WILL** be expected to be paid **PRIOR** to being seen by the Doctor at the next visit.

**PAIN MEDICATION**

\_\_\_\_\_(Initial) I acknowledge that pain medication will only be given to me by this practice and I will not accept pain medication from any other providers without prior approval from this office. Also, I further acknowledge that pain medication will not be given to me **WITHOUT** an appointment.

**NO** refills will be given over the phone. So, please make sure you check prescriptions prior to leaving the office. **NO EXCEPTIONS WILL BE MADE.**

**PAYMENTS**

\_\_\_\_\_(Initial) I understand that I am responsible to keep my account up to date. Co-pays and co-insurances are expected at the time of each visit, and I understand that is a contract between myself and my insurance company. I further understand that if I have a balance for any reason it will be expected to be **PAID IN FULL** prior to or at my next appointment unless prior arrangements have been made. If no prior arrangements have been made and you are unwilling to pay the balance at the appointment, you will be asked to reschedule and possibly incur the \$40 late cancellation charge.

**FORMS**

\_\_\_\_\_(Initial) I acknowledge that there will be a \$25 form fee for any forms that need to be completed by the office, this would include but is not limited to... disability paperwork, insurance forms, work verification and etc. Forms will **NOT** be released if fee is not paid. **\*\*\*All paperwork will be addressed within 7-10 business days\*\*\***

I have read and understand all of the above office policies and procedures.

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

\_\_\_\_\_  
Date