Hogue Chiropractic: The Road to Health and Wholeness
Mark Hogue, D.C. Matavia Johnson-Wellness Advocate
142 North Gamble Street Shelby, Ohio Phone:
419-342-2931 Fax: 419-347-7096 Date: ________________

Confidential Patient Information

Patients Name: ______________________________ Chief Complaint: ______________________________
Address: ______________________________ Home Phone: ______________________________
City: ______________State______ Zip:________ Cell Phone: ______________________________
SS#: ______________________________ Email: ______________________________
Date of Birth: ______________________________ Marital Status: M S W D
Occupation: ______________________________ Employer: ______________________________
Children:______________________________Pets:______________________________

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: ______________________________ Ins. Phone #: ______________________________
ID#: ______________________________ Group #: ______________________________
Name of Policy Holder: ______________________________ Policy Holder DOB: ______________________________
Policy Holders Employer: ______________________________

Family Physician: ______________________________ (Note: May we send your health information to this provider **Y / N**)
Person to contact in case of emergency (Name and Phone): ______________________________
Have you ever been under Chiropractic Care? Y N If so, who? ______________________________
Have you had any SPINAL X-Ray / MRI / CT' taken in the last year? Y N If so, where? ______________________________
What operations have you had? ______________________________ When? ______________
Serious Illness: ______________________________ When? ______________
Infectious Diseases: ______________________________ When? ______________
Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**
What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ________
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: ______________________________
What is your goal in our office? ______________________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Hogue Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________ ______________________________
Signature of Insured / Guardian Date

Confidential Patient Information and Case History Continued Name________________________

Date________________________

Do you have or have ever had any of the following diseases or conditions?:

Y N Heart attack/stroke	Y N Heart surgery	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Mitral valve prolapse	Y N Artificial valves	Y N Alcohol/drug abuse	Y N Venereal disease(STD))
Y N Hepatitis	Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema	Y N Glaucoma	Y N Anemia
Y N High/low blood pressure	Y N Psychiatric problems	Y N Rheumatic fever	Y N Frequent/severe headache
Y N Kidney problems	Y N Ulcers/Colitis	Y N Sinus problems	Y N Fainting/Seizures/Epilepsy
Y N Asthma	Y N Diabetes	Y N Tuberculosis	Y N Difficulty breathing
Y N Chemotherapy/radiation	Y N Low back problems	Y N Artificial bones/joint	Y N Arthritis

List any other serious medical conditions you have or ever had:________________________

____

List anything you are allergic to:________________________

____

List any serious accidents or falls with dates:________________________

____

Family health history:________________________

____

Do you: Take supplements or vitamin: yes__no__/ Exercise: yes__no__/ Are on a special diet: Yes__no__

Do you smoke: yes__no__Vape: yes__no__ Chew: yes__no__ How much?:__________How long?:______________

Are you wearing heel lifts________ Sole lifts_______ Inner soles______ Arch supports______

Do you wear your seatbelt?: yes__no___ What is the age of your mattress?__________ Is it comfortable: yes__no__

For Women: Are you taking birth control? Yes__no__ Are you pregnant? Yes___/How long?______No______

Nursing? Yes__No___

1) Constitutional: 1) sitting or standing blood pressure______,2) Supine blood pressure______, 3) Pulse rate and Regularity____________4) Respirations_______,5) Temperature______, 6) Height______7) Weight _________

4) Nervous/psychiatric:

5)

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419-342-2931(phone)

Patient Name: ______________________ **Date:** ____________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **The Ohio State Chiropractic Association**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, ______________________ being the parent or legal guardian of ______________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ______________________

Children: ______________________

Others: ______________________

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ______________________

Signature: ______________________ Date: ______________________