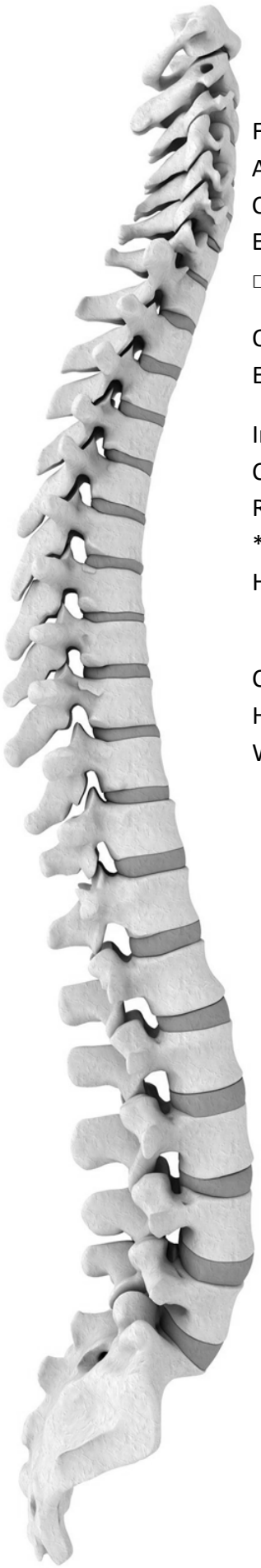
Welcome to De Brine Family Chiropractic!



668 A Phillips Road, Victor New York 14564
Phone: 585-398-7620 Fax: 585-869-5451

PATIENT INFORMATION

Full Name: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ □ Male □ Female
□ Minor □ Single □ Married □ Other | □ Unemployed □ Disabled □ Student

Occupation: _____ Employer: _____
Employer Address: _____

Insurance Company: _____ ID # _____
Cardholder's Name (as appears on card): _____
Relationship to Patient: _____ Cardholder's Birth Date: _____
*Primary Care Physician: _____ Location: _____
How did you hear about us? _____

PHONE NUMBERS
Cell: (_____) _____
Home: (_____) _____
Work: (_____) _____

*** IN CASE OF EMERGENCY, CONTACT ***
Name: _____
Relationship: _____
Phone: (_____) _____
(_____) _____

List any medications you are currently taking:

_____

List any allergies you have:

_____

Exercise:
□ None □ Daily
□ Moderate □ Heavy

Work Activity:
□ Sitting □ Standing
□ Light Labor □ Heavy Labor

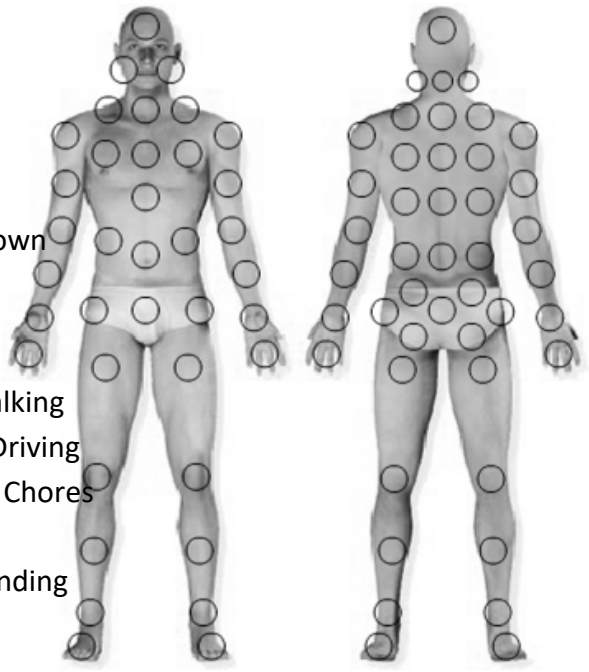
Miscellaneous:
□ Smoking: Packs per week _____
□ Alcohol: Drinks per week _____
□ Caffeine: Cups per day _____
□ Stress Level & Reason _____

As per your policy: **YOUR COPAY IS**: $ _____ or ____ % of the charged amount after your deductible (set by your insurance policy) has been met.

Any treatment not covered by your copay will be your responsibility to pay. A statement will be sent to you after a claim has been sent and we have heard from your insurance company. If any supplements, orthotics, orthopedic appliances or other supplies are required for your care, it is your responsibility to pay for them. They are not returnable. If Radiological studies are necessary for your care, you are responsible for any co-payment due to the radiologist. If you read and understand the waiver, please sign below. If you do not understand, please ask your doctor to clarify it for you.

Patient Signature _____ Date _____

PATIENT CONDITION:



- Mark on the diagram to the right where you are feeling discomfort.
- Rate the severity of your pain today on a scale from 1 (least pain) to 10 (severe pain) _____
- When did your symptoms appear? _____
- Is this condition getting progressively worse? □ No □ Yes □ Unknown
- Of the following, check all that apply:

Difficulty with: □Employment □Homemaking □Lifting □Personal Care □Sitting □Sleeping □Social Life □Standing □Traveling/Driving □Walking

Due to: □Bending over □Climbing Stairs □Concentrating □Dressing □Driving □Exercising □Getting In & Out of Car □Getting to Sleep □Household Chores □Lifting □Looking Over Shoulder □Lying Down □Reaching Overhead □Rising Out of Chair □Shopping □Showering/Bathing □Sitting □Standing □Staying Asleep □Using Computer □Walking □Yard Work

Quality: □Aching □Annoying □Burning □Deep □Diffuse □Dull □Heavy □Intolerable □Pulling □Sharp □Stabbing □Stiff □Throbbing □Tightness □Tingling □Constant □Frequent □Intermittent □On/Off □Random □Recurring

- What treatment(s) or medication(s) have you received for your condition?

_____

_____

- Name and Location of any other doctor(s) who have treated you for this condition and when:

_____

Indicate if you have or have had any of the following. If there is history in your family, mark to the side with " * "

AIDS/HIV	□ Yes □ No	Goiter	□ Yes □ No	Pneumonia	□ Yes □ No
Alcoholism	□ Yes □ No	Gonorrhea	□ Yes □ No Gout	Polio	□ Yes □ No
Allergy Shots	□ Yes □ No		□ Yes □ No	Prostate Problem	□ Yes □ No
Anemia	□ Yes □ No	Heart Disease	□ Yes □ No	Prosthesis	□ Yes □ No
Anorexia	□ Yes □ No	Hepatitis	□ Yes □ No	Psychiatric Care	□ Yes □ No
Appendicitis	□ Yes □ No	Hernia	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Arthritis	□ Yes □ No	Herniated Disk	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Asthma	□ Yes □ No	Herpes	□ Yes □ No	Scarlet Fever	□ Yes □ No
Auto Immune Disease	□ Yes □ No	High Blood Pressure	□ Yes □ No	Sexually Transmitted	
Bleeding Disorders	□ Yes □ No	High Cholesterol	□ Yes □ No	Disease	□ Yes □ No
Breast Lump	□ Yes □ No	Kidney Disease	□ Yes □ No	Stroke	□ Yes □ No
Bronchitis	□ Yes □ No	Liver Disease	□ Yes □ No	Suicide Attempt	□ Yes □ No
Bulimia	□ Yes □ No	Measles	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cancer	□ Yes □ No	Migraine Headaches	□ Yes □ No	Tonsillitis	□ Yes □ No
Cataracts	□ Yes □ No	Miscarriage	□ Yes □ No	Tuberculosis	□ Yes □ No
Chemical Dependency	□ Yes □ No	Mononucleosis	□ Yes □ No	Tumors, Growths	□ Yes □ No
Chicken Pox	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Typhoid Fever	□ Yes □ No
Diabetes	□ Yes □ No	Mumps	□ Yes □ No	Ulcers	□ Yes □ No
Emphysema	□ Yes □ No	Osteoporosis	□ Yes □ No	Vaginal Infections	□ Yes □ No
Epilepsy	□ Yes □ No	Pacemaker	□ Yes □ No	Whooping Cough	□ Yes □ No
Fractures	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Other _____	
Glaucoma	□ Yes □ No	Pinched Nerve	□ Yes □ No	_____	

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: _____

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

De Brine Family Chiropractic, P.C.

Dr. Karen L. De Brine, D.C.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages Please call:

[ ] my home

[ ] my work

[ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____