New Patient Information Name: _____ Date: _____

Kemp Chiropractic Center

Address: _____ Phones: Hm.) _____ Gender M/F

_____ Wk.) _____ Birthdate: _____

_____ Cell) _____

Email Address: _____ Occupation: _____

Legal Status: Minor___ Single___ Married___ Divorced___ Widow(er)___

Spouse's Name: _____ Parent or Legal Guardian's Name: _____

How did you hear about us? _____

Briefly describe the reason(s) for your visit to our office today. _____

_____

Financial Information

Person Ultimately Responsible for account: _____Relationship to patient: _____

Billing Address: _____ City, State & Zip _____

Insurance Information

Primary Insurance Co: _____Insured's Name: _____& D.O.B._____

Secondary Insurance Co: _____ Insured's Name: _____& D.O.B._____

AUTHORIZATIONS

I hereby authorize Dr. Monica Kemp of Kemp Chiropractic Center and her designees/assistants to administer such treatment as is necessary, and to perform any procedures as are necessary on the basis of her findings during the course of my treatment.

Signature: _____ Date: _____

Kemp Chiropractic Center is hereby authorized to release any information deemed appropriate concerning my physical condition to any insurance company or insurance adjustor in order to process ay claim for reimbursement of charges incurred by me as a result of professional services rendered.

Signature: _____ Date: _____

CONFIDENTIAL HEALTH HISTORY Name: _____ Date: _____

Is your visit today due to: ___Emergency ___New injury ___Old injury ___Chronic Pain ___ Other

Are you in pain today? Y/N If so, please rate you pain with this scale (mild) 1-2-3-4-5-6-7-8-9-10(severe)

When did your current condition first occur? _____How? _____

Is it getting worse? Y/N …better? Y/N Does it interfere with: __work __sleep __daily routine

Have you ever been treated by a medical doctor for this or similar conditions? Y/N _____

Have you ever been treated by a chiropractor for this or similar conditions? Y/N _____

List all medications, vitamins, or supplements that you take: _____

_____

List all surgeries & when: _____

_____

List all major accidents & when: _____

_____

CIRCLE any of the following conditions if you have **EVER** experienced them:

Alcoholism	Congenital heart defect	HIV+	Rheumatic Fever
Anemia	Diabetes	Hypoglycemia	Shingles
Arthritis	Diphtheria	Metabolic Syndrome	Stroke? TIA
Asthma	Eczema	Miscarriage	Surgical implants
Cancer	Emphysema	Polio	Tuberculosis
Corticosteroid Rx	Epilepsy	Psychiatric problems	Venereal Disease

Have you ever … **Please describe:**

…been knocked unconscious? Y/N _____

…used a cane, crutch, or other support? Y/N _____

…been treated for a spine or nerve disorder? Y/N _____

…had a fractured bone? Y/N _____

…been hospitalized other than for surgery Y/N _____

Are you dieting to lose or gain weight? Y/N Actively exercising? Y/N Ever used IV drugs? Y/N

Do you use tobacco? ___Smoke ___ chew how much? _____

Do you drink alcohol? Y/N how much? _____

Family health history is important for us to know. List any major illnesses (or cause of death) for the following:

Mother:

Father:

Maternal grands:

Paternal grands:

Siblings:

Confidential Health History – Page 2 Name: _____ Date: _____

Please indicate the approximate date of you last…

	Less than 6 mo.	6-18 mo.	Over 18 mo.	Never
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐

Please **CIRCLE** any of the following that you have experienced over the past **6 MONTHS**

GENERAL

Allergies
Anxiety
Depression
Dizziness
Fainting
Fatigue
Fever/Chills
Headache
Insomnia
Immunodeficiency
Neuralgia
Seizures
Sleep Loss
Sweats
Thyroid Problems
Tremors
Weight loss

RESPIRATORY

Asthma
Chronic cough
Difficulty breathing

GENITOURINARY

Bedwetting
Frequent urination
Incontinence
Kidney infection/Stone
Painful Urination
Urinary retention
UTI

MUSCLE/JOINT

Arthritis
Bursitis
Hernia
Low back Pain
Mid Back Pain
Neck pain/stiffness
Poor Posture
Sciatica
Spinal curvature
Swollen joints
Pain/Numbness of:
shoulders
shoulder blades
arms
elbows
hands
hips
legs
knees
Feet
tailbone

SKIN

Boils
Bruise easily
Hives/itching
Rash
Varicose Veins
Warts/mole changes

GASTRO-INTESTINAL

Belching/gas
Colitis
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gallbladder trouble
Hemorrhoids
Jaundice
Nausea
Poor appetite
Stomach Pain
Ulcers
Vomiting
Vomiting of blood

BONE

Infection
Osteoporosis
Tumor

WOMEN ONLY

Cramps/backache
Hot Flashes
Irregular cycle
Pregnancy

MEN ONLY

Prostate trouble

EYES/EARS/NOSE & THROAT

Colds
Deafness
Earaches
Ear noises
Enlarged Glands
Enlarged thyroid
Eye Pain
Gum Trouble
Hoarseness
Nose bleeds
Sinus Infection
Sore throat
Tonsillitis
Visual disturbances

CARDIO-VASCULAR

Ankle swelling
Arteriosclerosis
Bleeding disorder
Chest Pain
High blood pressure
Low blood pressure
Poor circulation
Irregular heart beat
Pacemaker
Rapid heart beat
Slow heart beat

Kemp Chiropractic Center

Electronic Health Records Intake Form

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred Method of communication for patient reminders (Circle one): Email/Cell phone/Home phone
Preferred Phone Number _____

Date of Birth:
____/ ____/ _____

Gender (Circle one):
Male Female

Preferred Language:
English
Other _____

CMS requires providers to report both race and ethnicity

Smoking Status (Circle one):
Every day smoker
Occasional smoker
Former smoker
Never smoker

Race (Circle one):
American Indian or Alaska Native
Asian
Black or African American
White (Caucasian)
Other
I Decline to Answer

Ethnicity (Circle one):
Hispanic or Latino
Not Hispanic or Latino
I decline to answer

Are you currently taking any medications? Yes _____ (list below) No_____

Medication Name	Dosage (i.e. 5mg, etc)	Frequency (i.e. once a day, etc)

Do you have any medication allergies? Yes _____ (list below) No_____

Medication Name	Reaction	Onset Date (approx.)

Patient Signature: _____ Date: _____

For office use only – DO NOT COMPLETE THIS SECTION

Height: _____ Weight: _____ Blood Pressure: _____/_____

Kemp Chiropractic Center
34 Parkway Commons Way

Greer, SC 29650

864-848-6890

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.

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; organ donation; research; criminal activity; military activity and national security; Worker's Compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you 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.

PLESE SIGN BACK AND RETURN TO FRONT DESK

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 the 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: _____