***PLEASE ASK RECEPTIONIST IF YOU NEED ASSISTANCE**

PATIENT INFORMATION

Name: _____ **Date of Birth**: _____ **Age**: _____
Address: _____ **City**:_____ **State**: _____ **Zip**: _____
Home Phone: _____ **Cell Phone**: _____ **SS#**:_____
□□Male □□Female □□ Right handed□□ Left handed
Marital Status: □□Married □□Single □Divorced □□Separated □□Widowed

Your Occupation: _____**Employer**:_____ **Work Phone**: _____
Weight Frequently Required to Lift is Under: □10lbs □20lbs □30lbs □40lbs □More_____

Name of Spouse or Nearest Relative:_____ **Phone**:_____
Spouse's Occupation: _____ **Employer**: _____ **Work Phone**:_____

Referred to This Office by: □Screening – Where _____ □Yellow Pages □Direct Mail
□Newspaper □Clinic Location □Online/Facebook □Friend – Name _____

Payment for Services Will be by: □Cash □Check □Credit Card (Visa and MasterCard ONLY)
□Health Insurance _____ □Auto Insurance _____
Policy Holder: _____ Policy holder date of birth: _____
Are you covered by more than one Insurance company? □Yes □No Name_____

MEDICAL/FAMILY HISTORY

Please indicate which conditions have been experienced by marking the appropriate boxes

S=Self M=Mother F=Father

S	M	F		S	M	F		S	M	F	
□	□	□	anemia	□	□	□□	dislocated joints	□	□	□□	neck pain
□	□	□	arthritis	□	□	□□	epilepsy	□	□	□□	nervousness
□	□	□	asthma	□	□	□□	German measles	□	□	□□	numbness
□	□	□□	back pain	□	□	□□	headaches	□	□	□□	polio
□	□	□□	bladder trouble	□	□	□□	heart trouble	□	□	□□	poor circulation
□	□	□□	bone fracture	□	□	□□	indigestion	□	□	□□	hepatitis
□	□	□□	bowel control loss	□	□	□□	high blood pressure	□	□	□□	rheumatic fever
□	□	□□	cancer	□	□	□□	HIV/ARC	□	□	□□	rheumatism/scarlet fever
□	□	□□	chest pain	□	□	□□	kidney disorder	□	□	□□	smoke cigarettes
□	□	□□	concussion	□	□	□□	reproductive disorders	□	□	□□	serious injury
□	□	□□	convulsions	□	□	□□	menstrual cramps	□	□	□□	sinus trouble
□	□	□□	diabetes	□	□	□□	multiple sclerosis	□	□	□□	tuberculosis
□	□	□□	drink alcohol	□	□	□□	muscular dystrophy	□	□	□□	venereal disease

Have you been treated by a physician for any health condition in the last year? □Yes □No
Describe Condition: _____ **Height**: _____ **Weight**: _____
Date of Last Physical Exam: _____ **Primary Care Physician**: _____

SURGICAL HISTORY

1._____ Date_____
2._____ Date_____
3._____ Date_____ (Additional space on back of form)

Do you have a metal implant? □□Yes □□No **Have you ever been gunshot?** □□Yes □□No
Do you have a pacemaker? □□Yes □□No **Do you have a defibrillator?** □□Yes □□No

ACCIDENT HISTORY

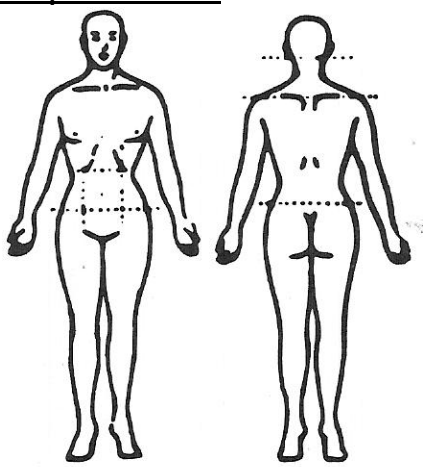
1. □Job □Auto □Other_____ Date_____(Additional space on back of form)

Patient's Signature_____**Date**_____
Assisted by: _____

RECEPTIONIST/ DOCTOR ASSISTED SIGHED;_____

PLEASE LIST MAJOR COMPAINTS:

Circle problem areas:



Please check the complaint(s) you have:

□ Neck pain □ Upper back pain □ Mid back pain □ Low back pain

□ Shoulder pain: Right / Left □ Leg pain: Right / Left □ Headaches

□ Arm pain: Right / Left □ Hip pain: Right / Left

□ Other _____

When and how did your symptoms occur? _____

_____

Symptoms developed from: □Job related injury □□Auto accident □□other accident □ □gradual onset **Date occurred**_____

Symptoms/Complaints: □□Come & Go □□Are constant

Symptoms have persisted for: _____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

Have you ever had these symptoms before? □□Yes □□No When?_____

If you were to guess, what do you think is causing your problem?

_____

Name and Location of Doctor(s) previously seen for present condition(s)/ Treatment

1._____/Treatment: _____

2._____/ Treatment: _____

Are you Allergic to any Medications? □□Yes □□No Which ones? _____

Are you taking any medications? □□Yes □□No Which ones? _____

Are you pregnant or think you may be pregnant? □□Yes □□No Date of last menstrual period _____

Please check the following activities that *aggravate* your condition:

□□Bending □□Reaching □□Straining at Stool □□Coughing □□Sitting □□Walking □□Lifting

□□Sneezing □□Lying down □□Turning your head □□Standing □□Sitting to standing

Please check the following activities that *relieve* your condition:

□□Bending □□Sitting □□Standing □□Lying down □□Walking

Fees are payable at the time x-rays, examination, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature_____ Date_____

Revised05012017

153 Center Rd.
Venice, Florida 34285
Ph: 941/488-5553 Fax: 941/218-6596

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN (HIPPA) ACKNOWLEDGEMENT FORM

Dr. Brian C Gibson DC

I _____have had the opportunity to read a copy of Dr. Brian C
(PRINT NAME)

Gibson's Notice of Patient's HIPPA Privacy Practice. ***HIPPA*** stands for *the* ***Health Portability and Accountability Act.*** For more information review :
http: www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf *Page 5634*

Authority of Personal Representative to Sign for Patient (if applicable):

___ Parent ___ Guardian ___ Power of Attorney ___ Other: _____

I authorize the release of information including:

- Diagnosis, records, treatment(s) rendered to me and insurance claims information.

This information may be released to:

___ Spouse _____

___ Child(ren) _____

___ Other _____

___ Information is not to be released

****Please note that we do not have encrypted Email and will not risk sending any patient information via email as most email services do not utilize encrypted email.***
We will be happy to make copies and fax, send or hand you requested information with reasonable notice.

Signature of Patient, Parent or Legal Guardian

_____ _____
(SIGNATURE) **(DATE)**

153 Center Rd.
Venice, Florida 34285
Ph: (941)488-5553 Fax: (941)218-6596

Directive of Payment:
Personal Injury, Medicare, and Insurance Assignment of Benefits:
Authorization and Signature on File:

Re: _____(patient)
Medicare ID: _____
Insurance ID: _____
PIP Claim No:_____

1) I authorize providers ***Drs. Gibson***; to use my name on any and all forms or documents which relate to Medicare, Personal Injury Protection (auto PIP), and all other health insurance benefits which relate to me and my dependents.
2) I authorize the release of information related to any claims to my Personal Injury, Medicare, and all Insurance companies or other relevant parties.
3) I understand that ***I am responsible for all charges*** and agree to pay for all services provided to me ***that are not covered by PIP, Medicare or other insurances***.
4) I authorize ***Drs. Gibson and staff*** to act as my agents in helping me obtain from PIP, Medicare and/or my Insurance companies.
5) I assign and authorize payment of PIP, Medicare, and Insurance health benefits related to services rendered in this office otherwise payable to me, directly to providers, ***Dr. Gibson.***
6) I ***assign payment directly to providers Dr. Gibson*** all Personal Injury, Medicare and all other insurance benefits for services rendered in this office.
7) I authorize and permit a copy of my signature on this ***Authorization and Signature on File*** to be used in place of the original on all insurance submissions.
8) I authorize and demand that ***Drs. Gibson*** file an appeal to Insurance companies on my behalf if necessary.

Consent of Treatment:

I voluntarily consent to the rendering of care; including the performance of diagnostic procedures. I understand that I am under the care and supervision of ***Drs. Gibson, DC*** and it is the responsibility of the staff to carry out the instructions of ***Drs. Gibson.***

*Signature:*_____ *Date:*_____

*Printed Name:*_____ *Relationship:*_____

*Witness:*_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask any questions before you sign if there is anything that is unclear.

Patient Name: _____ Today's Date:_____

The nature of the chiropractic adjustment:
The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move joints. They may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may sense a feel of movement and often some relief.

Analysis/Examination/Treatment:
As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- ▪ Spinal Manipulative Therapy
- ▪ Range of Motion Testing
- ▪ Muscle Strength Testing
- ▪ Radiographic Studies
- ▪ Palpation
- ▪ Orthopedic Testing
- ▪ Posture Analysis
- ▪ Hot/Cold Therapy
- ▪ Vital Signs
- ▪ Basic Neurological Testing
- ▪ EMS
- ▪ Other (specify)_____

The material risks inherent in chiropractic adjustments:
As with all healthcare procedures, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness or the bone which we can check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments and the same as a physical therapist and medical doctor. The other complications are also generally described as rare.

The availability and nature of other treatment options:
Other treatment options for your condition may include:

- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose the above noted "other treatment options" you should be aware that there are more serious risks and benefits of such options you may wish to discuss with your primary medical physician.

The risks and dangers of remaining untreated:
Remaining untreated may allow worsening of your condition, and/or the formation of adhesions and reduce mobility which may set up a pain reaction reducing further mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. More serious treatment such as surgery may result from being untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read (or have been read) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Brian Gibson and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient's Signature Date signed

_____ _____
Patient's Name (printed) Doctor's signature (Dr. Brian C Gibson DC)