

Grandview Chiropractic Center

Dr. Barry Radandt
2430C N. Grandview Blvd. • Waukesha, WI 53188

CONFIDENTIAL PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Birthdate: ____ - ____ - ____ Age: _____ SSN: _____
Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ Email: _____
Referred by: ☐ Our Website ☐ Phonebook ☐ Walk-In ☐ Insurance Company
☐ A Current Patient: _____ ☐ Other: _____

Claim / Insurance Information:

Claim Type: ☐ Self - Pay ☐ Insurance ☐ Auto Accident ☐ Worker's Comp ☐ Personal Injury
Primary Insurance: _____ Policyholder's Employer: _____
Policyholder's Name: _____ Policyholder's Birthdate: ____ - ____ - ____
Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Secondary Insurance: _____ Policyholder's Name: _____

Authorizations:

Please initial by each statement and sign below to indicate your acceptance of stated terms:

- _____ 1. I certify that I am the patient (or authorized representative of the patient) and all information I furnish is current, valid, and complete.
- _____ 2. I authorize the release of all necessary medical information to any designated insurance carrier, attorney, or third-party administrator for claim processing and payment.
- _____ 3. I assign all payments from any insurance carrier, attorney, or third-party administrator for medical services rendered to me (or my dependents) to be made directly to this clinic.
- _____ 4. I understand that my payment (including co-pay, co-insurance, and deductible amounts) is due at the time of service. Payment plans can be arranged upon request.
- _____ 5. I understand that I am personally responsible for full payment of all medical services rendered to me (or my dependents), regardless of insurance or financially-responsible-party coverage, partial payment(s), and/or termination of medical treatment.

Patient (or Authorized Rep.) Signature: _____ Date: _____

Authorized representative's relationship to patient: _____

Continue on other side →

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NOTICE OF PRIVACY PRACTICES (FEDERAL HIPAA PRIVACY ACT)

Effective Date for this Notice: February 2010

This notice describes how your protected health information may be used and disclosed, your rights as a patient, our legal duties with respect to your information, and how you can access additional information.

We may use or disclose your health information for the following purposes:

- **Treatment:** to all providers and staff within our clinic that are involved with your care; to other health care providers consulting with your care; and for contacting you about appointments, treatment options, and clinic-related information.
- **Billing and Collection:** to your insurance carrier and/or financially-responsible party to obtain payment for your medical services.
- **Health Care Operations:** for quality control; for office administration, development, and record-keeping; and for training providers and staff within our clinic.

Your rights with respect to your health information allow you to:

- Inspect and obtain a copy of your health record
- Amend your health record and/or request a restriction on certain uses and disclosures of your information
- Receive confidential communications by alternative means or locations
- Obtain a paper copy of notice upon request
- File a complaint regarding our privacy notice or practices

We are required by law to:

- Maintain the privacy of your protected health information
- Provide you with a notice of our privacy practices, including any future revisions
- Abide by the terms of this notice

Contact for additional information:

If you have any questions, concerns, or complaints about our privacy policies, your privacy rights, and/or your protected health information, please contact the **Clinic Privacy Director** at:

Grandview Chiropractic Center
2430 N. Grandview Blvd. Unit C • Waukesha, WI 53188
Phone: (262) 542-2553 • Fax: (262) 522-6867

CONSENT FOR TREATMENT

I hereby authorize all providers and staff at this clinic to perform treatment on me. Treatment may include, but not limited to: chiropractic adjustments, examinations, therapies, and x-rays. I understand that in any practice of medicine there may be risks or complications associated with treatment. I do not expect the provider(s) to be able to anticipate and explain all risks possible with chiropractic treatment, but I have been given the opportunity to ask questions and discuss my concerns. Therefore, I wish to rely on the judgment of the provider(s) during the course of my treatment and care, based on the facts then known.

I, _____, have read both the NOTICE OF PRIVACY PRACTICES and
Print Your Name CONSENT FOR TREATMENT. I accept the terms of each.
Patient (or Authorized Rep.) Signature: _____ Date: _____

Witness Signature and Date

Continue on other side →

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TODAY'S CHIROPRACTIC VISIT

Patient Name: _____

Date: _____

Have you ever received chiropractic care? ☐ Yes ☐ No When? _____

Was previous care for the same reason as today's visit? ☐ Yes ☐ No

List your symptoms you wish to seek chiropractic care for today: _____

When did your symptoms begin? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- ☐ Constantly (75-100% of time)
- ☐ Frequently (50-75% of time)
- ☐ Occasionally (25-50% of time)
- ☐ Intermittently (0-25% of time)

Does anything **ease** your symptoms?

- ☐ Nothing Eases
- ☐ Sleeping / Resting
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ Other: _____
- ☐ Walking / Exercise
- ☐ Heat
- ☐ Ice
- ☐ Medication
- ☐ Massage / Therapy

What best describes your symptoms?

- ☐ Sharp
- ☐ Burning
- ☐ Dull
- ☐ Throbbing
- ☐ Numbness / Tingling – Where? _____
- ☐ Shooting / Radiating – Where does the pain travel to? _____

Does anything **aggravate** your symptoms?

- ☐ Nothing Aggravates
- ☐ Sleeping / Resting
- ☐ Sitting / Driving
- ☐ Standing
- ☐ Stretching / Straining
- ☐ Walking / Exercise
- ☐ Other: _____
- ☐ Sneezing / Coughing
- ☐ Bending
- ☐ Lifting / Pulling
- ☐ Turning
- ☐ Heat / Ice
- ☐ Massage / Therapy

When are your symptoms the worst?

- ☐ Morning
- ☐ Evening / Night
- ☐ Afternoon
- ☐ Always the Same

Circle the intensity of your symptoms:

0	1	2	3	4	5	6	7	8	9	10
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No Pain → Excruciating

List any other care, treatments, tests, or medications you have received for your symptoms: _____

Please list any questions or concerns that you have: _____

Continue on other side →

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HEALTH HISTORY

List any medications you are taking: _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Fainting / Seizures / Epilepsy | <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Artificial Bones / Joints | <input type="checkbox"/> Arthritis |

List any other serious medical conditions that you have or had: _____

List any allergies: _____

List any previous surgeries and treatments with dates: _____

List any past serious accidents with dates: _____

List any **family** health history that you feel is important to share: _____

Do you take supplements? ☐ Yes ☐ No Please list: _____

Do you exercise? ☐ Yes ☐ No Type of activity and consistency: _____

Do you smoke? ☐ Yes ☐ No How much and for how long? _____

Do you wear shoe inserts? ☐ Yes ☐ No

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

For Females: Are you pregnant? ☐ Yes ☐ No ☐ Not Sure For how long? _____
Are you nursing? ☐ Yes ☐ No

Patient Signature: _____

Date: _____

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