Cowell Chiropractic

714.777.3200
4455 E. La Palma Avenue Anaheim, CA 92807

Today's Date: _____ /_____ /_____

Legal Name: _____

☐ Male ☐ Female Preferred Name: _____

Date of Birth: _____ /_____ /_____ Age: _____

Social Security #: _____-_____-_____

Home Address: _____

_____
City State Zip

Cell Phone #: (_____)_____

Home Phone #: (_____)_____

Work #: (_____)_____ Ext.____

Best Phone # to Call: ☐ Cell ☐ Home ☐ Work

E-mail: _____

Preferred Method of Communication (Circle One):
Phone Text E-mail U.S Mail

Occupation: _____

Employer: _____How Long? _____

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Referred By: _____

Emergency Contact: _____

Relation: _____

Phone #: (_____)_____
Circle One: Cell Home Work

Insurance

☐ Yes, please bill my insurance for me as a courtesy.
I will provide a copy of my insurance card and will update my information when it changes.

☐ My insurance is in another person's name:
Insured's Name: _____

Insured's Date of Birth: _____ /_____ /_____

Insured's SS #: _____-_____-_____

Account Responsible

If anyone other than the patient is responsible for this account, please provide the responsible party's information here.

Name: _____

Relationship to Patient: _____

Billing Address: _____

_____
City State Zip

Social Security #: _____-_____-_____

Date of Birth: _____ /_____ /_____

Phone #: (_____)_____
Circle One: Cell Home Work

- We invite you to discuss with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.
- I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me, will immediately be due and payable.
- Reimbursement for services covered by your major medical insurance, including EOB's will be sent directly to you from your insurance company.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize my insurance benefits to be paid directly to Cowell Chiropractic. I also authorize Cowell Chiropractic to receive remittance advice and release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or personal information.

_____ _____ /_____ /_____
Patient's Signature (Guardian if under 18) Date

Reason for Visit

Have you ever been treated by a Chiropractor before?

☐ Yes ☐ No If yes, please explain: _____

_____

The reason for this visit is a result of (Please Circle):

Work Sports Auto Trauma Chronic

Explain what happened: _____

_____

_____

Please describe the pain and its location: _____

_____

_____

When did this condition begin? _____ /_____ /_____

Is this condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your:

(Please Circle) Work Sleep Daily Routine

If so, please explain: _____

_____

_____

Have you had this or similar conditions in the past?

☐ Yes ☐ No If yes, please explain: _____

_____

_____

_____

Have you been treated by a Medical Physician for this condition?

☐ Yes ☐ No If so, where? _____

_____

Health History

List medications here (or use a separate page):

_____

_____

_____

Have you ever had any of the following diseases/ medical condition(s)?

Y N Heart Attack/Stroke	Y N Heart Surge/Pacemaker
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Alcohol/Drug Abuse	Y N Venereal Disease
Y N Frequent Neck Pain	Y N Shingles
Y N High/Low Blood Pressure	Y N Emphysema/Glaucoma
Y N Severe/Frequent Headaches	Y N Psychiatric Problems
Y N Fainting/Seizures/Epilepsy	Y N Kidney Problems
Y N Diabetes	Y N Sinus Problems
Y N Lower Back Problems	Y N Difficult Breathing
Y N Tuberculosis	Y N Artificial Bones/Joint
Y N Heart Murmur	Y N Rheumatic Fever
Y N Artificial Valves	Y N Ulcers/Colitis
Y N Hepatitis	Y N Asthma
Y N Cancer	Y N Chemotherapy
Y N Anemia	Y N Arthritis

Please list any other serious medical condition(s) you have or have ever had: _____

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any past serious accidents with dates: _____

_____

Do you smoke? ☐ Yes ☐ No How Much? _____

How Long? _____

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

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 ☐ No How Long? _____

Are you Nursing? ☐ Yes ☐ No

_____ _____ /_____ /_____

Patient's Signature (or Guardian) Date

Cowell Chiropractic
4455 E. La Palma Avenue
Anaheim, CA 92807
(714)777-3200
(714)777-3292 fax

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of *Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____

Date: _____/_____/_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

Dr. Nathan Cowell, D.C.
4455 E. La Palma Avenue
Anaheim, CA 92807
(714) 777-3200

I hereby request and consent to the chiropractic services of Nathan Cowell, D.C., associated licensed doctors and/or authorized persons who might now or in the future treat me while employed by, working or associated with, or serving as a back-up for Nathan Cowell, D.C. in an attempt to improve my physical condition.

I understand the purpose of this and subsequent visits are to acquire chiropractic care. A natural and conservative approach to my health needs, chiropractic care utilizes manipulation or joint adjustments, exercise, nutrition, and various modes of physiotherapy.

I understand that a definitive diagnosis may require further test (e.g. x-rays, laboratory test, MRI, etc.) and/or referrals to other health care professionals. Although Dr. Cowell may prescribe or suggest these tests or referrals, it is my responsibility to schedule an appointment and to acquire these test and/or referrals.

I understand and am informed that some risks are associated with chiropractic treatment, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes, and paralysis. I do not expect Dr. Cowell to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on his judgment during the course of the procedures, which he feels is in my current best interests.

The body's (nervous and musculoskeletal systems) reaction to Dr. Cowells chiropractic treatments maybe a generalized soreness over and around the area of my chief complaint. This is a normal and expected result because the muscles in the area have been stressed (spasm) and the bones misaligned. During my treatment, Dr. Cowell will be releasing stress on my spine, bones, joints, and surrounding soft tissues (e.g. muscles, tendons, ligaments, bursae, and nerves). This process breaks up the pain and spasm cycle in my body, but in doing so, my body may require time to adjust to these physiological changes.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. Cowell of any unusual symptoms that might occur.

In signing this informed consent form, I affirm that I have read this form in its entirety and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic treatment, the management of my case, and the related risks to chiropractic treatment as been answered to my satisfaction.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____ _____/_____/_____
Patient Name (Please Print) Date

_____
Patient Signature (Guardian if under 18)