**Dr. Armando R. Babcock, D.C 316-612-0600** TRINITY Chiropractic **3300 N Rock Road, Suite A2 Wichita, KS 67226**

# New Patient Form

**Today's Date:** _____

**Full Name:** _____

**Address**: _____ **Sex**: ○ M ○ F

**City**: _____ **State**: _____ **Zip**: _____

**H. Phone**: _____ **C. Phone**: _____

**Preferred contact method:** ○ Home Phone ○ Cell Phone ○ Email

**Emergency contact:** _____

**Number:** _____ **Relation:** _____

**E-mail**: _____

**Do we have permission to send you periodic emails?** ○Yes ○No

**Date of Birth**: _____ **SSN**: _____

**Status**: ○ Single ○ Married ○ Divorced ○ Other_____

**How did you hear about us:** ○ Internet ○ Ad ○ Friend ○ Family ○ Event ○ Existing patient: _____

**Occupation:** _____ **Employer**: _____

**Type of work**: ○ sitting ○ standing ; ○ Full time ○ Part time

**Do you have a primary care physician?** ○ Yes ○ No

**If yes,** Name: _____ Phone #: _____

Address: _____

**May we send updates to your provider regarding your care?** ○ Yes ○ No

**Are you seeing any other doctors for this condition?** ○ Yes ○ No

If yes, Name: _____ Phone #: _____

**Have you received previous chiropractic care**? ○Yes ○ No

If yes, when/where? _____

**Are you taking any medications?** ○ Yes ○ No

Please list: (Include medications, supplements, vitamins)

_____

_____

**Do you have any medication allergies?** ○ Yes ○ No

If yes, please list: (Please include reactions)

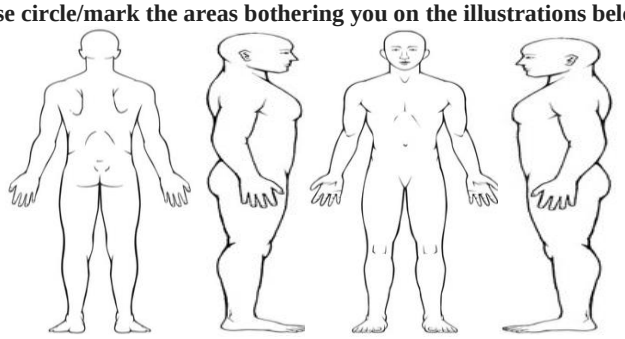
_____

_____

**(For women only) Are you pregnant?** ○ Yes ○ No

**What is your primary complaint?** _____

**Please circle/mark the areas bothering you on the illustrations below**.



**Is this related to** ○ an auto accident ○ a work injury ○ neither

If yes, when was the accident/injury? _____

**Have you ever been injured in an auto accident?** ○ Yes ○ No

If yes, when? _____

**Have you been diagnosed with a nerve disorder?** ○ Yes ○ No

If yes, what/when_____

**Had any X-Rays or MRIs taken for this condition?** ○ Yes ○ No

If yes, what/when_____

**Have you ever had a fractured/broken bone? ○ Yes ○ No**

If yes, what/when_____

**Surgeries/Hospitalizations:**

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

**What is your goal for your care?** ○ Pain Relief ○ Comprehensive

**What is your Race?** ○ Caucasian ○ American Indian ○ Asian ○ African American ○ Hispanic/Latino ○ Other _____

**Alcohol intake**: ○ Daily ○ Moderate ○ Socially ○ Never

**Caffeine intake**: ○ Never ○ Occasionally ○ Daily (Cups per day___)

**Recreational drug use**: ○ Never ○ Socially ○ Moderate ○ Daily

**Smoking Status:** ○ Daily ○ Occasional ○ Former ○ Never

**Eating Habits:** ○ One to two meals/day ○ Two to three meals/day

**Exercise Habits:** ○ Daily ○ Few times/week ○ Once/weekly ○ None

**Family History: Please mark below**

○ Alcoholism ○ Alzheimer's ○ Anemia ○ Arthritis ○ Asthma ○ Cancer ○ Dementia ○ Depression ○ Diabetes ○ Epilepsy ○ Heart Disease ○ High Blood Pressure ○ High Cholesterol ○ Kidney Disease ○ Liver Disease ○ Lung Disease ○ Osteoporosis ○ Stroke ○ Ulcers ○ Other: _____

**Please mark any health conditions that you currently have or have had in the past.**

○ **NO MEDICAL PROBLEMS** (Please mark here if you have no prior history of any significant medical problems)

**Do you have any:** ○ implants ○ pins ○ screws ‖ If yes, where? _____

**Musculoskeletal:** ○ Gout ○ Lupus ○ Osteoarthritis ○ Rheumatoid arthritis ○ Scoliosis ○ TMJ issues ○ Other_____

**Neurological:** ○ Anxiety ○ Cerebral Palsy ○ Depression ○ smell/vision/hearing loss ○ MS ○ Parkinson's ○ Polio ○ Stroke ○ Other_____

**Head/ENT:** ○ Earaches ○ Headaches ○ Hearing loss ○ Sinus trouble ○ Tinnitus ○ Other_____

**Cardiovascular:** ○ Chest pain ○ Heart attack ○ Heart murmur ○ High/Low blood pressure ○ High cholesterol ○ Irregular beat ○ Other_____

**Respiratory:** ○ Asthma ○ COPD ○ Cystic Fibrosis ○ Emphysema ○ Pneumonia ○ Pulmonary Embolism ○ Tuberculosis ○ Other_____

**Gastrointestinal:** ○ Acid reflux ○ Diverticulitis ○ GI bleed ○ Irritable bowel ○ Inflammatory bowel disease ○ Peptic/stomach ulcer ○ Other_____

**Genitourinary:** ○ Bladder issues ○ Dialysis ○ Kidney problems ○ Kidney stones ○ Urinary tract infections ○ Other_____

**Endocrine:** ○ Diabetes ○ Hashimoto's Thyroiditis ○ Hypo/Hyperglycemia ○ Hyper/Hypothyroidism ○ Osteoporosis ○ Thyroid cancer ○ Other_____

**Dermatological/Hematopoietic:** ○ Acne ○ Easy bruising ○ Eczema ○ Psoriasis ○ Skin cancer ○ Other_____

**Any medical problems NOT listed:**

_____

**Dr. Armando R. Babcock, D.C 316-612-0600** TRINITY Chiropractic **3300 N Rock Road, Suite A2 Wichita, KS 67226**

Before our office begins any treatment, we need informed consent for treatment and HIPAA Disclosure consent. Please read each statement and **write your initials** to the left of the statement your agreement with the terms below.

**Please initial below on the lines to the left of each statement:**

— I hereby authorize this office and its staff to examine and treat my and/or my dependents condition as the doctor sees fit and can best help in the restoration of my and/or my dependents health. I also understand that chiropractic manipulation is designed to correct or reduce vertebral subluxation. In addition to the many benefits of chiropractic care, there are also some risks including but not limited to sprains, fractures, disc injury, burns, dislocations, and strokes. Chiropractic is a separate and distinct healing art from medicine and does not cure any disease or condition.

— I grant permission to be called to confirm or reschedule an appointment or called for any missed appointments and to be sent occasional cards, letters, emails, or health information as an extension of my care in this office.

— I acknowledge and agree that all services rendered to me and/or my dependents are charged directly to me and that I am personally responsible. I also understand that if I suspend or terminate care for myself and/or my dependents, any fees for services rendered will still be my responsibility.

— As a courtesy, Trinity Chiropractic will verify and file my health/accident insurance if provided. However, verification of my insurance benefits does NOT guarantee payment for services rendered to me and/or my dependents. As such, in the event of non-payment from my health insurance or limitations, I am personally responsible for payment in full.

— I hereby assign and transfer all medical benefits to which I am entitled. This is an assignment of my rights and benefits. I hereby authorize and direct payments of insurance and/or Medicare benefits be issued directly to Trinity Chiropractic for medical services rendered to myself and/or my dependents. If these payments are made out to me directly, I grant Trinity Chiropractic the full power and authority in my name to endorse any and all checks.

— I understand that in the course of an examination performed by Dr. Babcock, diagnostics are important elements of chiropractic care. Chiropractors rely on diagnostic techniques in order to fully understand what is occurring in the musculoskeletal system. Chiropractic care uses spinal manipulation and an X-Ray can show the alignment and structure of the body. If necessary, Dr. Babcock may take diagnostic X-rays. I have the right to refuse, in writing, to take X-Rays.

I, _____, hereby authorize Trinity Chiropractic to disclose any information necessary such as past, present, and future periods of health care information to insurance carriers, attorneys, or adjusters regarding my treatments, process insurance claims generated in the course of examination or treatment, and allow a photocopy of my signature to be used to process insurance claims. I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and that it would then no longer be protected by federal privacy regulations. I have the right to refuse to sign this Authorization form. If signed, I have the right to revoke this authorization in writing at any time. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I have the right to review the Notice of Privacy Policies attached.

_____ _____

**Patient (or Guardian's) Signature** **Date**

_____

**Date of Birth**

---

# (Fill out the consent below if the patient is under 18 years of age.)

I, _____, being the parent and/or legal guardian of _____ do hereby give my consent to any medical care such as an evaluation and/or treatment determined by a physician to be necessary for the welfare of my child.

_____ _____

**Parent (or Guardian's) Signature** **Date**