PREMIER CHIROPRACTIC CENTER
CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Ext: _____

Age: ____ Birth Date: _____ Social Security #: _____

Sex: Male___ Female___ Marital: M S W D How Many Children?_____
Occupation: _____ Employer: _____
Work Address: _____ City: _____ State: ___ Zip: _____
Name of Spouse: _____ Spouse's Employer: _____
Patient's Nearest Relative: _____ Address: _____
Date of Last Physical Exam: Medical_____ Chiropractic: _____
Operations Have You Had? _____
When? _____
Referred By:_____

Have You Ever Suffered From: (Please Place an "X" in the spaces provided)

Dizziness_____	Backaches_____	Heart Trouble_____	Diabetes_____
Tuberculosis_____	Arthritis_____	Asthma_____	Numbness_____
Headaches_____	Neuritis_____	Digestive Disorders_____	Nervousness_____
Cancer_____	Anemia_____	Rheumatic Fever_____	Sinus Trouble_____

Purpose of this Appointment:_____

Other Doctors Seen for this Condition:_____

Is Your Illness/Injury Work Related: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No

Has a Physician treated you for any health condition in the last year? ☐ Yes ☐ No
Describe:_____

What medications are you taking?:_____

Remarks or Additional Information:_____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Premier Chiropractic Center, Ltd. to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Premier Chiropractic Center, Ltd. to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE:_____ DATE:_____
Patient (over 18 years) or responsible party

PREMIER CHIROPRACTIC CENTER

DR. JOHN BOUMA ◊ CHIROPRACTOR

419 CENTER STREET, SUITE B, GRAYSLAKE, ILLINOIS 60030

(847)543-1055

HIPAA AUTHORIZATION FORM
Authorization For Disclosure of Information
From Health Care Records

1. The Following specific doctor or health care facility is authorized to make the requested use of disclosure:

2. The following person or class of persons may receive disclosure of protected health information about me:

   Premier Chiropractic Center, Ltd.
   419 Center Street; Suite B
   Grayslake, Illinois 60030

3. Specific Information to be Disclosed includes all records in the possession of this health care provider including inpatient and outpatient hospital records, including those from the emergency room, physician records, surgical reports, office notes, reports of examination, prescription forms, nursing records, reports of all diagnostic testing including, but not limited to, x-rays, MRI's, CT Scans, EMG's, and EEG's.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying PREMIER CHIROPRACTIC CENTER, LTD. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. **A copy of this Authorization may be used the same as the original.**

6. This authorization expires on_____, 20___, or upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

_____ _____ _____
Patient's Signature **Date of Signature** **Date of Birth**

-Or, if Applicable-

_____ _____
Signature of Guardian/ or Personal Representative of Patient's Estate/ Representative's Authority to Act for the Ind.

Personal Description of Guardian/ Personal Representative

_____
Date of Guardian or Personal Representative's Signature