PATIENT INFORMATION

Date:_____

Name:_____ Social Security #:_____

Address:_____ City/St/Zip:_____

Phone (c):_____ (h):_____ (o):_____

D.O.B.:____/____/____ Age:_____ Gender: M F Email : _____

Employer:_____ Occupation:_____

Spouse:_____ Names and ages of children:_____

How did you hear about our office:_____

Have you seen a chiropractor previously?: Y N If yes, Chiropractor's name:_____

Emergency Contact: _____ Phone: _____ Relation: _____

Describe your present complaint and how it occurred:_____

_____

_____

_____

Are you taking any medication? ❑ Yes ❑ No

If Yes, What are you taking: _____

_____

Please list surgeries:_____

_____

_____

If we will be filing insurance for you, please have your insurance card(s) available for us to make a copy of, as well as your drivers license. Thank you!

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENELY EXPERIENCING

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid Back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Headaches/Migraines
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast
- ❑ **Pregnant**

Due Date: _____

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Gall bladder problems
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

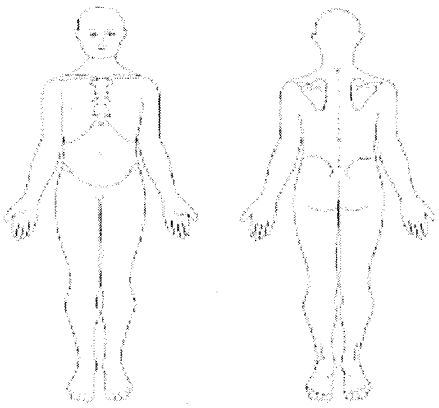
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
  - ❑ High
  - ❑ Low
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain
- ❑ Difficult breathing through nose

SYMPTOM LOCALIZATION



Draw letter over area of complaint (s)

P = Pain N = Numb S = Spasm

T = Tender B = Burning

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature: _____

MORTON CHIROPRACTIC'S OFFICE POLICY

Patient Name _____

OFFICE: We believe that a clear definition of our office policies will allow us to concentrate on "The Big Issue" REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of our office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know.

Initials ____ AUTHORIZATION FOR PAYMENT: It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us.

1. The privilege of insurance assignment begins when our office receives your insurance forms and coverage has been verified.
2. If filing insurance, I hereby authorize Morton Chiropractic to furnish any and all medical records that my insurance company may request for payment of my charges.
3. If I am choosing not to file insurance, I understand that I am expected to make payment at the time of service and agree to make payment in accordance with this policy.

Initials ____ PHONE CONTACT: Dr. Morton and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, follow thru medical information, treatment alternatives, or other health related information. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By initialing you are giving us authorization to contact you and to leave messages on your answering machine or with individuals at your home or place of employment.

Initials ____ INFORMED CONSENT: The patient has been informed and understands that the practice of chiropractic includes treatment by manipulation of the patient's body, including the spine. Manipulation of the body and the spine necessarily involves applying pressure, by the use of "hands on" techniques which require Dr. Morton to use her hands and body to cause appropriate movement within the patient's body. Manipulation by a chiropractor should not cause damage to the patient.

Manipulation of the patient by Dr. Morton will necessarily involve physical contact between Dr. Morton and the patient. The patient acknowledges that the general nature of this physical contact has been explained to them by Dr. Morton prior to commencement of treatment and examination. During treatment Dr. Morton may touch the patient's body in a variety of areas including near the patient's groin, the patient's buttock, and near the patient's breasts. If the patient feels that such potential for contact may be distressing or uncomfortable the patient should either avoid chiropractic treatment with this chiropractor or, in writing request that an observer be present during treatment and examination, subject to any applicable charge.

If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs, you will immediately inform Dr. Morton and give her sufficient notice to allow her to alter the treatment plan as appropriate.

Initials ____ THANK YOU CARDS: If you refer a friend, family member or colleague to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a thank you card.

Initials ____ REFERRAL BOARD: If you refer a friend, family member or colleague to our office, we would like to put your first name and first initial of your last name on our referral board, thanking you for sending that person to our office. By initialing this form you are giving us authorization to display your name on our board.

Initials ____ FINANCIAL ARRANGEMENTS: We have an open front desk and many of our financial arrangements are discussed at the front counter. Please do not initial this if you would prefer to have your financial arrangements discussed in a more private place.

I have read and fully understand all of the above information. I acknowledge that I have read or received a copy of Dr. Morton's Notice of Privacy Practices. I also understand that my refusing to sign this form means that I will not be treated at this office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care for Minor _____

Effective Date of This Notice: September 28, 2009

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Morton Chiropractic, PLLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at the office please contact the office at (405) 509-6060.

I. How Morton Chiropractic, PLLC may Use or Disclose Your Health Information

Morton Chiropractic, PLLC collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Morton Chiropractic, PLLC, but the information in the medical record belongs to you. Morton Chiropractic, PLLC protects the privacy of your health information. The law permits Morton Chiropractic, PLLC to use or disclose your health information for the following purposes:

1. Treatment. We may disclose information regarding your treatment to other health care providers who have requested information pertaining to your treatment.

2. Payment. In the event that your health insurance company should need specific information regarding your health care in order to issue payment, we will provide the information to the entity issuing the request.

3. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

4. Required by law. As required by law, we may use and disclose your health information.

5. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

6. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

7. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

8. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

9. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

10. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

11. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

12. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

13. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services.

14. Change of Ownership. In the event that Morton Chiropractic, PLLC is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When Morton Chiropractic, PLLC May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Morton Chiropractic, PLLC will not use or disclose your health information without your written authorization. If you do authorize Morton Chiropractic, PLLC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Morton Chiropractic, PLLC is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your health information.

4. You have a right to request that Morton Chiropractic, PLLC amend your health information that is incorrect or incomplete. Morton Chiropractic, PLLC is not required to change your health information and will provide you with information about the office's denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by Morton Chiropractic, PLLC, except that Morton Chiropractic, PLLC does not have to account for the disclosures described in parts 1 (treatment) and 2 (payment) of section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Morton Chiropractic, PLLC, 45 East 15th Street Edmond, OK 73013.

IV. Changes to this Notice of Privacy Practices

Morton Chiropractic, PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Morton Chiropractic, PLLC is required by law to comply with this Notice. In the event that is notice is changed a copy of the revised version will be mailed to the address we have on file.

V. Complaints

Complaints about this Notice of Privacy Practices or how Morton Chiropractic, PLLC handles your health information should be directed to Morton Chiropractic, PLLC, 45 East 15th Street Edmond, OK 73013.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your compliant to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html