

Red Rock Chiropractic Center

New Patient Form (Ages 5-17)

OFFICE USE ONLY	
Height _____	Weight _____
BP _____	
Pulse _____	Shoe Size _____

PATIENT INFORMATION	FAMILY INFORMATION
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss Sex: <input type="checkbox"/> M <input type="checkbox"/> F First name: _____ Middle name: _____ Last name: _____ Suffix: _____ Preferred name (Nickname): _____ Age: _____ Birth date: ___/___/____ Address: _____ City: _____ State: _____ Zip: _____ Home phone: (____) _____ - _____ Cell phone (child's): (____) _____ - _____ Parent home email: _____ Best Contact Method: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Home email	Mother's name: _____ Mother's cell phone: _____ Mother's employer: _____ Mother's work phone: _____ Father's name: _____ Father's cell phone: _____ Father's employer: _____ Father's work phone: _____ Siblings names and ages _____ _____
EMERGENCY CONTACT INFORMATION	
Emergency contact name: _____ Emergency contact phone: (____) _____ - _____ Emergency contact alternate phone: (____) _____ - _____ Relationship to patient: _____	
SCHOOL & HOBBIES	PRIMARY CARE PHYSICIAN
Current school _____ Current grade in school _____ Special services currently being received in school or privately _____ _____ Favorite hobbies or interests: _____ _____ _____	Primary care physician name: _____ Clinic name: _____ City: _____ Phone: (____) _____ - _____
REFERRAL SOURCE	
How did you hear about us? <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Phone book <input type="checkbox"/> Radio <input type="checkbox"/> Physician _____ <input type="checkbox"/> Massage therapist _____ <input type="checkbox"/> Referral/word of mouth _____	
PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance company: _____ Policyholder name: _____ Relationship to patient: _____ Policy number: _____ Group number: _____ Person responsible for payment: _____ Deductible: _____ Amt met this year: _____ Co-pay: _____	Insurance company: _____ Policyholder name: _____ Relationship to patient: _____ Policy number: _____ Group number: _____ Person responsible for payment: _____ Deductible: _____ Amt met this year: _____ Co-pay: _____
PATIENT PREFERENCES	PREVIOUS CHIROPRACTIC CARE
In the event you need to have therapy for greater than 5 minutes, what is your favorite music to listen to for relaxing? _____ _____	Have you seen a chiropractor before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when was the last time you have seen one? _____ How many chiropractic visits have you had this year? _____
ADDITIONAL SERVICES	
Please mark any services besides chiropractic adjustments you might be interested in receiving here: <input type="checkbox"/> Decompression <input type="checkbox"/> Hydromassage <input type="checkbox"/> Food sensitivity testing <input type="checkbox"/> Blood/lab testing for an in-depth health analysis <input type="checkbox"/> DOT physicals <input type="checkbox"/> Sports physicals <input type="checkbox"/> In-office rehab <input type="checkbox"/> Custom-made orthotics <input type="checkbox"/> Custom-made pillows <input type="checkbox"/> Drug/alcohol testing for your business <input type="checkbox"/> Functional medicine <input type="checkbox"/> MLS laser therapy <input type="checkbox"/> Weight loss <input type="checkbox"/> Exercise program <input type="checkbox"/> Pre-employment physicals	
REASON FOR VISIT	
What brings you to our office today? <input type="checkbox"/> Pain/symptom relief <input type="checkbox"/> Problem correction/prevention <input type="checkbox"/> Wellness/Overall health In your own words, tell us what you are looking for help with: _____ _____	

Health Questionnaire

Please mark the conditions for which you would like to be seen today.

- Headaches Jaw pain Neck pain Shoulder pain Arm pain Wrist pain Hand pain Upper back pain Mid back pain
Lower back pain Hip pain Knee Pain Leg pain Ankle pain Foot pain Other _____

Other Treatment

Please list any other treatments you have received and the providers you have seen for these conditions.

- Chiropractic _____ Neurology _____ Massage _____
Medication _____ Physical therapy _____ Surgery _____
Other _____

Daily Living Effects

Please mark which activities are affected by the above conditions: Employment Homemaking Lifting Personal care (washing, dressing, etc.) Sitting Sleeping Social life Standing Traveling Driving Walking Exercise Other _____

What is the most important thing you want to be able to do that you're currently not able to because of the condition(s)?

Feet/Orthotic History

What is your shoe size AND width? _____ **Do you currently wear orthotics?** No Yes

If yes, from where did you get them? Podiatrist Chiropractor Store (Walmart, etc.) Other _____

How many days per week do you wear these kinds of shoes? Athletic _____ Dress _____ High Heels _____ Flats _____ Industrial _____

Accidents, Injuries, Fractures, & Hospitalizations

Please list any previous accidents, injuries, fractures, and hospitalizations and approximate date of occurrence.

Accident & Date	Injury & Date	Fracture & Date	Hospitalization & Date
<input type="checkbox"/> No previous accidents	<input type="checkbox"/> No previous injuries	<input type="checkbox"/> No previous fractures	<input type="checkbox"/> No previous hospitalizations
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.

Diagnostic Imaging

Please mark any diagnostic imaging and approximate date of occurrence.

X-ray & Date	MRI & Date	CT Scan & Date	Bone Density & Date
<input type="checkbox"/> No previous x-rays	<input type="checkbox"/> No previous MRIs	<input type="checkbox"/> No previous CT Scans	<input type="checkbox"/> No previous bone densities
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.

Surgeries

Please mark any previous surgeries and list the approximate date of occurrence.

Surgery/Year	Surgery/Year	Surgery/Year	Surgery/Year

General Health History

STRESS
Please circle your daily stress level: 0 1 2 3 4 5 6 7 8 9 10 Have you ever sought help for a mental health issue? Yes No

SLEEPING PATTERN
Please circle how many hours of sleep you get per night: 0 1 2 3 4 5 6 7 8 9 10 What is your sleep quality? Excellent Good Fair Poor
Please circle how many times your sleep is interrupted per night: 0 1 2 3 4 5 6 7 8 9 10

Current Medications/Vitamins

Please list current medications and vitamins including dosage, if known.

I am currently not taking any medications.

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Women Only

Are you pregnant? Yes No Unsure If pregnant, what is your due date? ____ / ____ / ____

Social History

Caffeine used Often Occasionally Never **Chew tobacco** Often Occasionally Never **Wear seatbelt** Always Usually Never

Drink alcohol Often Occasionally Never **Exercise** Often Occasionally Never

Family History

Alzheimer's	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Diabetes	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Osteoporosis	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Arthritis	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Epilepsy	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Psychiatric	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Cholesterol	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Heart problems	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Stroke	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling
Cancer	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	High blood pressure	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling	Thyroid	<input type="checkbox"/> Parent <input type="checkbox"/> Sibling

Substance Abuse		
Alcohol <input type="checkbox"/> Past <input type="checkbox"/> Present	Cocaine <input type="checkbox"/> Past <input type="checkbox"/> Present	Marijuana <input type="checkbox"/> Past <input type="checkbox"/> Present
Amphetamines <input type="checkbox"/> Past <input type="checkbox"/> Present	Crystal Meth <input type="checkbox"/> Past <input type="checkbox"/> Present	Other _____ <input type="checkbox"/> Past <input type="checkbox"/> Present
Barbiturates <input type="checkbox"/> Past <input type="checkbox"/> Present	Heroin <input type="checkbox"/> Past <input type="checkbox"/> Present	
Recreational Activities		
<input type="checkbox"/> Backpacking	<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Swimming
<input type="checkbox"/> Baseball	<input type="checkbox"/> Hockey	<input type="checkbox"/> Tennis
<input type="checkbox"/> Basketball	<input type="checkbox"/> Hunting	<input type="checkbox"/> Track
<input type="checkbox"/> Biking	<input type="checkbox"/> Racket ball	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Boating	<input type="checkbox"/> Running	<input type="checkbox"/> Walking
<input type="checkbox"/> Fishing	<input type="checkbox"/> Skiing	<input type="checkbox"/> Weight lifting
<input type="checkbox"/> Football	<input type="checkbox"/> Soccer	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Golf	<input type="checkbox"/> Softball	<input type="checkbox"/> Other _____
Do you carry a back pack? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many hours per day do you watch TV?	How many hours per day do you play computer games? _____

MEDICAL HISTORY

Please indicate if you have ever experienced or have been diagnosed as having any of the following:

Abdominal pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Double vision	<input type="checkbox"/> Past <input type="checkbox"/> Present	Ovarian cysts	<input type="checkbox"/> Past <input type="checkbox"/> Present
Acne	<input type="checkbox"/> Past <input type="checkbox"/> Present	Drowning	<input type="checkbox"/> Past <input type="checkbox"/> Present	Panic attacks	<input type="checkbox"/> Past <input type="checkbox"/> Present
ADD/ADHD	<input type="checkbox"/> Past <input type="checkbox"/> Present	Dyslexia	<input type="checkbox"/> Past <input type="checkbox"/> Present	Paranoia	<input type="checkbox"/> Past <input type="checkbox"/> Present
Allergy shots	<input type="checkbox"/> Past <input type="checkbox"/> Present	Ear pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Passive/aggressive behavior	<input type="checkbox"/> Past <input type="checkbox"/> Present
Anemia	<input type="checkbox"/> Past <input type="checkbox"/> Present	Easy bleeding	<input type="checkbox"/> Past <input type="checkbox"/> Present	Peeling	<input type="checkbox"/> Past <input type="checkbox"/> Present
Anger	<input type="checkbox"/> Past <input type="checkbox"/> Present	Easy bruising	<input type="checkbox"/> Past <input type="checkbox"/> Present	Pinched nerves	<input type="checkbox"/> Past <input type="checkbox"/> Present
Animal bites	<input type="checkbox"/> Past <input type="checkbox"/> Present	Eczema	<input type="checkbox"/> Past <input type="checkbox"/> Present	Pinkeye	<input type="checkbox"/> Past <input type="checkbox"/> Present
Anxiety disorder	<input type="checkbox"/> Past <input type="checkbox"/> Present	Energy level problem	<input type="checkbox"/> Past <input type="checkbox"/> Present	Pneumonia	<input type="checkbox"/> Past <input type="checkbox"/> Present
Arthritis	<input type="checkbox"/> Past <input type="checkbox"/> Present	Epilepsy	<input type="checkbox"/> Past <input type="checkbox"/> Present	Poison ivy (oak, sumac)	<input type="checkbox"/> Past <input type="checkbox"/> Present
Asthma	<input type="checkbox"/> Past <input type="checkbox"/> Present	Eye injury	<input type="checkbox"/> Past <input type="checkbox"/> Present	Poor coordination	<input type="checkbox"/> Past <input type="checkbox"/> Present
Athlete's foot	<input type="checkbox"/> Past <input type="checkbox"/> Present	Eyestrain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Poor posture	<input type="checkbox"/> Past <input type="checkbox"/> Present
Autism/Autism spectrum disorder	<input type="checkbox"/> Past <input type="checkbox"/> Present	Fainting	<input type="checkbox"/> Past <input type="checkbox"/> Present	Post nasal drip	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bed wetting	<input type="checkbox"/> Past <input type="checkbox"/> Present	Fatigue	<input type="checkbox"/> Past <input type="checkbox"/> Present	Premenstrual syndrome	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bipolar disorder	<input type="checkbox"/> Past <input type="checkbox"/> Present	Fevers/chills/sweats	<input type="checkbox"/> Past <input type="checkbox"/> Present	Psoriasis	<input type="checkbox"/> Past <input type="checkbox"/> Present
Blacking out	<input type="checkbox"/> Past <input type="checkbox"/> Present	Foul odor of urine	<input type="checkbox"/> Past <input type="checkbox"/> Present	Rashes	<input type="checkbox"/> Past <input type="checkbox"/> Present
Blood in urine	<input type="checkbox"/> Past <input type="checkbox"/> Present	Fractured jaw	<input type="checkbox"/> Past <input type="checkbox"/> Present	Repetitive motion injury	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bloody stools	<input type="checkbox"/> Past <input type="checkbox"/> Present	Frequent colds	<input type="checkbox"/> Past <input type="checkbox"/> Present	Rheumatic fever	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bone pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Frequent headaches	<input type="checkbox"/> Past <input type="checkbox"/> Present	Ringing in ears	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bowel problems	<input type="checkbox"/> Past <input type="checkbox"/> Present	Frequent urination	<input type="checkbox"/> Past <input type="checkbox"/> Present	Scoliosis	<input type="checkbox"/> Past <input type="checkbox"/> Present
Braces	<input type="checkbox"/> Past <input type="checkbox"/> Present	Frostbite	<input type="checkbox"/> Past <input type="checkbox"/> Present	Seizures/Convulsions	<input type="checkbox"/> Past <input type="checkbox"/> Present
Breathing problems	<input type="checkbox"/> Past <input type="checkbox"/> Present	Glasses/contacts	<input type="checkbox"/> Past <input type="checkbox"/> Present	Self-esteem issues	<input type="checkbox"/> Past <input type="checkbox"/> Present
Brittle nails	<input type="checkbox"/> Past <input type="checkbox"/> Present	Growing pains	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sensitivity to light	<input type="checkbox"/> Past <input type="checkbox"/> Present
Broken bones	<input type="checkbox"/> Past <input type="checkbox"/> Present	Hay fever	<input type="checkbox"/> Past <input type="checkbox"/> Present	Serious fall(s) or repetitive falls	<input type="checkbox"/> Past <input type="checkbox"/> Present
Broken/knocked out teeth	<input type="checkbox"/> Past <input type="checkbox"/> Present	Head injury	<input type="checkbox"/> Past <input type="checkbox"/> Present	Severe headaches	<input type="checkbox"/> Past <input type="checkbox"/> Present
Bronchitis	<input type="checkbox"/> Past <input type="checkbox"/> Present	Hearing loss	<input type="checkbox"/> Past <input type="checkbox"/> Present	Shortness of breath	<input type="checkbox"/> Past <input type="checkbox"/> Present
Burning urination	<input type="checkbox"/> Past <input type="checkbox"/> Present	Heart disease	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sinus problems	<input type="checkbox"/> Past <input type="checkbox"/> Present
Burns	<input type="checkbox"/> Past <input type="checkbox"/> Present	Heat exhaustion/heat stroke	<input type="checkbox"/> Past <input type="checkbox"/> Present	Skin ulcers	<input type="checkbox"/> Past <input type="checkbox"/> Present
Changes in moles	<input type="checkbox"/> Past <input type="checkbox"/> Present	Hiccups	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sleep problems	<input type="checkbox"/> Past <input type="checkbox"/> Present
Chemical insensitivities	<input type="checkbox"/> Past <input type="checkbox"/> Present	Hyperventilation	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sleeping disorders	<input type="checkbox"/> Past <input type="checkbox"/> Present
Chicken pox	<input type="checkbox"/> Past <input type="checkbox"/> Present	Hypoglycemia (low blood sugar)	<input type="checkbox"/> Past <input type="checkbox"/> Present	Snoring	<input type="checkbox"/> Past <input type="checkbox"/> Present
Choking	<input type="checkbox"/> Past <input type="checkbox"/> Present	Illnesses accompanied by a high fever	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sore throat	<input type="checkbox"/> Past <input type="checkbox"/> Present
Chronic ear infections/earaches	<input type="checkbox"/> Past <input type="checkbox"/> Present	Ingrown toenails	<input type="checkbox"/> Past <input type="checkbox"/> Present	Spinning/balance	<input type="checkbox"/> Past <input type="checkbox"/> Present
Chronic fatigue	<input type="checkbox"/> Past <input type="checkbox"/> Present	Insect stings	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sports injury	<input type="checkbox"/> Past <input type="checkbox"/> Present
Cold sores	<input type="checkbox"/> Past <input type="checkbox"/> Present	Insomnia	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sprains/strains	<input type="checkbox"/> Past <input type="checkbox"/> Present
Concussion	<input type="checkbox"/> Past <input type="checkbox"/> Present	Itching	<input type="checkbox"/> Past <input type="checkbox"/> Present	Suicidal thoughts	<input type="checkbox"/> Past <input type="checkbox"/> Present
Constipation	<input type="checkbox"/> Past <input type="checkbox"/> Present	Jaw pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Sunburn	<input type="checkbox"/> Past <input type="checkbox"/> Present
Corns and calluses	<input type="checkbox"/> Past <input type="checkbox"/> Present	Joint pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Present
Cough/Wheezing	<input type="checkbox"/> Past <input type="checkbox"/> Present	Joint stiffness	<input type="checkbox"/> Past <input type="checkbox"/> Present	Swollen glands	<input type="checkbox"/> Past <input type="checkbox"/> Present
Coughing of phlegm	<input type="checkbox"/> Past <input type="checkbox"/> Present	Lazy eye	<input type="checkbox"/> Past <input type="checkbox"/> Present	Tingling sensations	<input type="checkbox"/> Past <input type="checkbox"/> Present
Coughing up blood	<input type="checkbox"/> Past <input type="checkbox"/> Present	Lice	<input type="checkbox"/> Past <input type="checkbox"/> Present	Tourette's syndrome	<input type="checkbox"/> Past <input type="checkbox"/> Present
Cross eye	<input type="checkbox"/> Past <input type="checkbox"/> Present	Lower side pain	<input type="checkbox"/> Past <input type="checkbox"/> Present	Toxic shock syndrome	<input type="checkbox"/> Past <input type="checkbox"/> Present
Croup	<input type="checkbox"/> Past <input type="checkbox"/> Present	Meningitis	<input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble sleeping through the night	<input type="checkbox"/> Past <input type="checkbox"/> Present
Cuts, scrapes, punctures	<input type="checkbox"/> Past <input type="checkbox"/> Present	Menstrual cramps	<input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble with bladder control (enuresis)	<input type="checkbox"/> Past <input type="checkbox"/> Present

Deformity	<input type="checkbox"/> Past <input type="checkbox"/> Present	Menstrual problems	<input type="checkbox"/> Past <input type="checkbox"/> Present	Unconsciousness	<input type="checkbox"/> Past <input type="checkbox"/> Present
Dehydration	<input type="checkbox"/> Past <input type="checkbox"/> Present	Mood swings	<input type="checkbox"/> Past <input type="checkbox"/> Present	Unusual stress	<input type="checkbox"/> Past <input type="checkbox"/> Present
Depression	<input type="checkbox"/> Past <input type="checkbox"/> Present	Muscle ache	<input type="checkbox"/> Past <input type="checkbox"/> Present	Urinary infection	<input type="checkbox"/> Past <input type="checkbox"/> Present
Diarrhea	<input type="checkbox"/> Past <input type="checkbox"/> Present	Muscle weakness	<input type="checkbox"/> Past <input type="checkbox"/> Present	Vaginal yeast infection	<input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty urinating	<input type="checkbox"/> Past <input type="checkbox"/> Present	Neck or back problems	<input type="checkbox"/> Past <input type="checkbox"/> Present	Visual impairment	<input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty walking	<input type="checkbox"/> Past <input type="checkbox"/> Present	Neurological disorders	<input type="checkbox"/> Past <input type="checkbox"/> Present	Warts	<input type="checkbox"/> Past <input type="checkbox"/> Present
Digestive disorders	<input type="checkbox"/> Past <input type="checkbox"/> Present	Nosebleed	<input type="checkbox"/> Past <input type="checkbox"/> Present	Weakness	<input type="checkbox"/> Past <input type="checkbox"/> Present
Dislocations	<input type="checkbox"/> Past <input type="checkbox"/> Present	Numbness	<input type="checkbox"/> Past <input type="checkbox"/> Present	Weight loss/gain	<input type="checkbox"/> Past <input type="checkbox"/> Present
Dizziness	<input type="checkbox"/> Past <input type="checkbox"/> Present	Obsessive compulsive disorder	<input type="checkbox"/> Past <input type="checkbox"/> Present	Other: _____	<input type="checkbox"/> Past <input type="checkbox"/> Present

Number of doses of antibiotics taken in the past 6 months: _____	Total number of doses of antibiotics taken during lifetime: _____	Adverse reaction to any vaccinations (even if mild) If yes, please explain: _____
Number of doses of other prescription medications taken in the past 6 months: _____	Total number of doses of other prescription medications during lifetime: _____	

Consent to Treat a Minor

(for patients 17 years of age and younger)

I hereby request and authorize Dr. Kyle Pankonin to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____.

This authorization is also intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child above.

(If applicable) Under the terms and conditions of my divorce, separation, and/or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

HIPAA Privacy Act

I have received RRCC, notice of HIPAA Privacy Act. I authorize RRCC to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of RRCC. I understand and agree that I am financially responsible to RRCC, for any and all charges not covered by insurance for myself, spouse, and dependents.

Patient or Legal Guardian Signature

Date

Consent to Electronic Communication

I acknowledge the privacy risks associated with using Electronic communications and authorize Red Rock Chiropractic Center staff and/or doctor to communicate with me or any minor dependent/ward for purpose of medical advice, education, clinical record summaries, full medical records, and/or appointment reminders. I understand that my e-mail address will not be given to anyone outside of this clinic for any reason and that this will be for medical purposes only.

Patient or Legal Guardian Signature

Date

Insurance Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Red Rock Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

I request that payment of authorized Medicare benefits be made of my behalf to Red Rock Chiropractic Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Responsible Party Signature

Date

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S

NAME _____
LAST FIRST INITIAL

ADDRESS _____
STREET CITY STATE ZIP

PHONE (_____) _____ BIRTH DATE _____ LAST 4 SSN _____

Please List Medical Facility:

1. NAME	2. NAME	3. NAME
ADDRESS	ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER	FAX NUMBER

The type of information to be used or disclosed is as follows:

- _____ X-rays Images (mailed) Radiology report (faxed) Dates requested _____
- _____ X-rays Images (mailed) Radiology report (faxed) Dates requested _____
- _____ X-rays Images (mailed) Radiology report (faxed) Dates requested _____
- _____ MRI Radiology report (faxed) Dates requested _____
- _____ MRI Radiology report (faxed) Dates requested _____
- _____ CT Scan Radiology report (faxed) Dates requested _____
- Lab work and current medication list Dates requested _____
- Other _____

Please mail requested images and fax requested reports by _____.

This information may be disclosed to and used by the following organization:

KYLE J. PANKONIN, D.C.
RED ROCK CHIROPRACTIC CENTER
202 MAINS STREET, PO BOX 517
LAMBERTON, MN 56152
PHONE: 507-752-7650
FAX: 507-752-7635

The reason for disclosure of this information is for the following reason:

- Continuing healthcare Personal Other _____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the medical record department. I understand the revocation will not apply to:

- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

SIGNED _____ DATE _____

(IF NOT PATIENT, STATE RELATIONSHIP)