Dr. Martin Schmaltz - Chiropractic Physician
7161 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4383

Confidential Patient Health Record

Personal Information

Last: ___________________________ First: ________________________ Middle: ___________

Birth Date: ____/___/_____ Age:_______ Sex: Male / Female Social Security # ________________

Address: ____ Apt # _____

City: _____________________________ State: __________________ Zip: __________________

Cell Phone: (______) ______-__________ Second Phone: (______) ______-__________

Email Address:____

Legal Guardian Information - if patient is a minor (under 18)

First Name: __________________ Last: _________________________ Relationship: ____________

Address (if different from above): ____

City: _____________________________ State: __________________ Zip: __________________

Cell Phone: (______) ______-__________ Second Phone: (______) ______-__________

Email Address:____

Emergency Contact

Last: ___________________________ First: ________________________ Middle: ___________

Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other ______________________________________

Cell Phone: (______) ______-____________ Second Phone: (______) ______-__________

Employment Information

Business Name:____

Job Activities: ____

Adult Illnesses: CHECK all health conditions. CIRCLE IF IT IS CURRENT

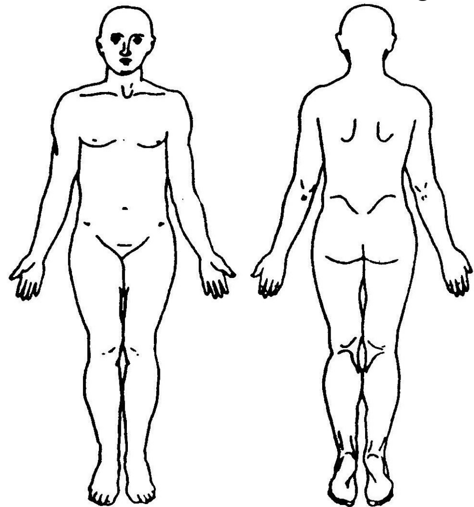
[ ] arthritis	[ ] heart disease	[ ] lung problems	[ ] Parkinson’s disease
[ ] cancer	[ ] HIV	[ ] lupus	[ ] seizures
[ ] diabetes	[ ] high blood pressure	[ ] multiple sclerosis	[ ] strokes
[ ] fibromyalgia	[ ] liver disease	[ ] Other _______________	______________________

Patient Name ________________________________ Date ____________________

Current Health Condition

Use the letters below to indicate the TYPE and LOCATION of your sensations right now.

Key: A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



Unwanted Condition (Why are you here today?)______________

____

When did this condition BEGIN? ______/______/________

Has it occurred before? [ ] Yes [ ] No When?_______________

Is the condition: [ ] Auto Injury [ ] Job Injury [ ] Home Injury

[ ] Slip or Fall [ ] Lifting [ ] Slept Wrong [ ] Unknown [ ] Other

Explain:____

____

Date of Accident: ____/____/______ Time of Accident: _______

INDICATE YOUR PAIN LEVELS BELOW FOR EACH INJURED AREA

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

When is the condition worse? [ ] when first get up [ ] morning

0 -1: NO PAIN- to just barely noticeable
2 - 3: MILD - Pain is present but does not limit your activities
4 - 5: MODERATE – You can do most activities with rest periods
6 - 7: SEVERE – Unable to do SOME activities because of pain
8 -9: EXTREME- Unable to do MOST activities because of pain
10: DISABLING – Unable to do ANY activities: including putting on clothes, bathing, cooking, driving, almost any movement

[ ] mid-day [ ] evening [ ] at night

What activities make the condition worse? ____

____

Are you experiencing any other symptoms or health problems? ______________________________

____

____

Previous care for this SAME CONDITION

[ ] I have not previously seen a doctor for this condition. OR FILL in the information BELOW

Have you seen other doctors for THIS CONDITION? [ ] No [ ] Yes If yes, when? ______/______/_________

Dr.'s Name: ___________________________ Type of treatment: __________________________

Was it beneficial in resolving condition? [ ] No [ ] Yes Explain: _______________________________

____

Previous Chiropractic Care:

[ ] I have not previously seen a chiropractor OR Fill in information BELOW

Dr.'s Name: ____________________ Location: _______________________ Date of last visit: ___________

Patient Name ______________________________ Date ____________________

Current Medications: List ANY/ALL medications you are CURRENTLY TAKING. Please be specific			
Medication	For What Condition?	Medication	For What Condition?

Surgery (ies): List all surgical procedures. Write the DATE of the procedure immediately afterward

Surgery	Date	Surgery	Date
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Injury (ies): List all injuries. Write the DATE of the injury immediately afterward

[ ] back injury
[ ] broken bones
[ ] disability (ies)
[ ] fall (severe)
[ ] head injury
[ ] industrial accident
[ ] joint injury
[ ] motor vehicle accident
[ ] other____________________

Insurance Information:

Who is responsible for your bill? YOU and ..... (mark appropriate box (es)) [ ] Myself only [ ] Spouse

[ ] Worker's Comp [ ] Auto Insurance [ ] Medicare [ ] Medicate [ ] Other (be specific) ________________

Personal Health Insurance Carrier: ____________________ Health ID Card #: ________________________

Policy Holder's Name: ______________________________ Group #: ______________________________

Policy Holders Date of Birth: _____/_____/_____ Primary Care Physician: ____________________

Workers Compensation Injury / Auto / Personal

Have you filed an injury report with your employer ? [ ] Yes [ ] No Date: ______/_____/_____ Time: _________

Carrier: ____ Policy # ____________________________

Carriers Phone #: (______) _________ - ___________________ Adjuster: ____________________________

Claim #: ____ Attorney: ____________________________

Patient Print Name: ___________________________________ Date: ______________________________

Patient's Signature: ___________________________________ Date: ______________________________

Signature of parent or legal guardian if patient is under 18 years old.

Guardian Print Name: ___________________________________ Date: ____________________________

Guardian's Signature: ___________________________________ Date: ____________________________

Dr. Martin Schmaltz, D.C.
North County Pain Relief Center
7157 - 7161 North Lindbergh Blvd., Hazelwood MO 63042
ph: 314.731.4383, fax: 314.731.4204

Patient: ____ Age: _________

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here: http;//ww.cms.hhs.gove/SecurityStandards/Downloads/securityproposedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This includes the named attorney of record representing you. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. A patient has the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial: Patient ________ OR Parent or Legal Guardian _____

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial: Patient ________ OR Parent or Legal Guardian _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial: Patient ________ OR Parent or Legal Guardian _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred. This includes release of medical & financial information to the patient's attorney.

Initial: Patient ________ OR Parent or Legal Guardian _____

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

Initial: Patient ________ OR Parent or Legal Guardian _____

Patient's Signature: ____________________________________ **Date:** _________________________________

Parent or Legal Guardian: ________________________________ **Date:** _________________________________