

Meridian Family Chiropractic
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CASE NO. _____

Please fill out the following form in as much detail as possible. Please print.

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

Cell Phone (Other contact number) _____

E-mail Address (for notifications) _____

Best way to notify you of appointments/reminders _____

Age _____ Date of Birth _____ Sex: (M) (F)

Social Security Number: _____

How did you hear about us? _____

Family Physician _____ Phone # _____

Employer _____ Phone # _____

Occupation _____

Married _____ Partnered _____ Single _____ Widowed _____ Divorced _____

of Children _____ Name of Spouse/Partner _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes _____ No _____ N/A _____

How will you pay for your appointment today?

_____ SELF PAY (Cash, Check, Credit card, Care Credit)

_____ Insurance (Please have insurance card available so we can make a copy)

Name of Insurance Company: _____

Name of Person Insurance Policy is under: _____

If not self, Social Security Number of Individual: _____

Date of Birth of Individual: _____

Office Notes:

PREGNANCY QUESTIONNAIRE

NAME: _____ DATE _____

DUE DATE: _____ SEX: MALE FEMALE NOT SURE

WHEN WAS YOUR LAST PREGNANCY EXAM? _____

WHAT WERE YOU TOLD ABOUT THE PROGRESSION OF YOUR PREGNANCY?

HOW MUCH WEIGHT HAVE YOU GAINED? _____

ARE YOU TAKING PRENATAL VITAMINS? YES NO

ANY CONCERNS FOR GESTATIONAL DIABETES? YES NO DON'T KNOW

WHEN WAS YOUR LAST ULTRASOUND? _____

DO YOU KNOW THE PRESENTATION OF YOUR BABY? YES NO

IF YES: NORMAL BREACH ANTERIOR OTHER: _____

PLEASE EXPLAIN ANY CONCERNS YOU MAY HAVE:

PATIENT'S SIGNATURE: _____

(Please do not write below this line.)

EXAM NOTES:

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now	Past		Now	Past
	N	P		N	P
Headaches _____ Frequency	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms	_____	_____	Colitis	_____	_____
Weakness in Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eye	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling Joints	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____
Face Flushed	_____	_____	Hayfever	_____	_____
Buzzing in Ears	_____	_____	Menstrual Difficulties	_____	_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____

PATIENT NAME _____

DATE _____

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name of Individual	Relationship to Patient
1.	
2.	
3.	

1. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone #: _____

Name _____ Phone #: _____

2. Can we send mail addressed to you to your home mailing address:

YES _____ No _____

3. Please mark if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ No _____

4. Can confidential messages be left on your telephone answering machine/voice mail?

YES _____ No _____

5. Can we send you e-mails regarding your appointments (ie. appointment reminders)?

YES _____ No _____

6. Do you give us permission to use your first name and last initial on our patient appreciation board?

YES _____ No _____

7. Do you give us permission to use your photo on our patient appreciation board (will only be used inside our office)?

YES _____ No _____

PATIENT

SIGNATURE: _____ DATE: _____

(Guardian if patient is under 18 years of age)

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Meridian Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Date

Signature

Print Name