HEALTHBRIDGE
CHIROPRACTIC

NEW PATIENT INFORMATION

NAME _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

SSN _____ DL# _____ BIRTHDAY _____ AGE _____ M/F _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ PHONE _____

NAME OF SPOUSE _____ DATE OF INJURY _____

PLEASE LIST MEDICATION: _____

_____

PLEASE LIST PAST SURGURIES/ MEDICAL HISTORY: _____

_____

CHECK THE SYMPTONS THAT MAY APPLY:

____HEADACHE ____NECK PAIN ____MID BACK PAIN ____LOWER BACK PAIN ____HIP PAIN ____THIGH/LEG PAIN ____FOOT PAIN ____CHEST PAIN

____NUMBNESS ____SHOULDER PAIN ____ELBOW PAIN ____WRIST PAIN ____DIZZINESS ____SHORTNESS OF BREATH ____FATIGUE ____CANCER

____DEPRESSION ____MEMORY LOSS ____HIV/AIDS ____ARTHRITIS ____ASTHMA ____DIABETES ____HEART DISEASE ____HIGH BLOOD PRESSURE

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ PHONE NUMBER _____

CURRENT MEDICAL DOCTOR _____ PHONE NUMBER _____

AUTOMOBILE ACCIDENT ---------- REFERRED BY _____

WERE YOU THE DRIVER, PASSANGER OR A PEDESTRIAN? (PLEASE CIRCLE ONE) DATE OF ACCIDENT _____

WERE YOU DRIVING YOUR OWN VEHICLE OR SOMEONE ELSES? (PLEASE CIRCLE ONE) IF SOMEONE ELSE'S PLEASE GIVE NAME AND NUMBER.

NAME _____ PHONE NUMBER _____

DO YOU OWN A RESGISTERED VEHICLE, WHETHER YOU DRIVE IT OR NOT? YES OR NO. DO YOU HAVE INSURANCE COVERAGE FOR THIS VEHICLE? YES OR NO DO YOU LIVE WITH A RELATIVE WHO OWNS A REGISTED VEHICLE? YES OR NO

DESCRIBE THE ACCIDENT _____

_____

HOSPITAL NAME _____ XRAYS (REGION) _____

PATIENT SIGNATURE _____ DATE _____

CENTER CITY
Academy House
1420 Locust St, Suite 220
Philadelphia, PA 19102
Phone: 215.546.0100

ELKINS PARK
928 Township Line Rd
Elkins Park, PA 19027
Phone: 215.782.1394

JUNIATA PARK
1216 E. Hunting Park Ave
Philadelphia, PA 19124
Phone: (267) 672-1262

MOUNT AIRY
7172 Ogontz Ave
Philadelphia, PA 19138
Phone: 267.672.1260

SOUTH PHILADELPHIA
1913 S. Broad St
Philadelphia, PA 19148
Phone: 215.755.5700

WEST PHILADELPHIA
6648 Lansdowne Ave
Philadelphia, PA 19151
Phone: 267.292.9200

ALLENTOWN
451 W. Linden St
Allentown, PA 18102
Phone: 484.201.2121

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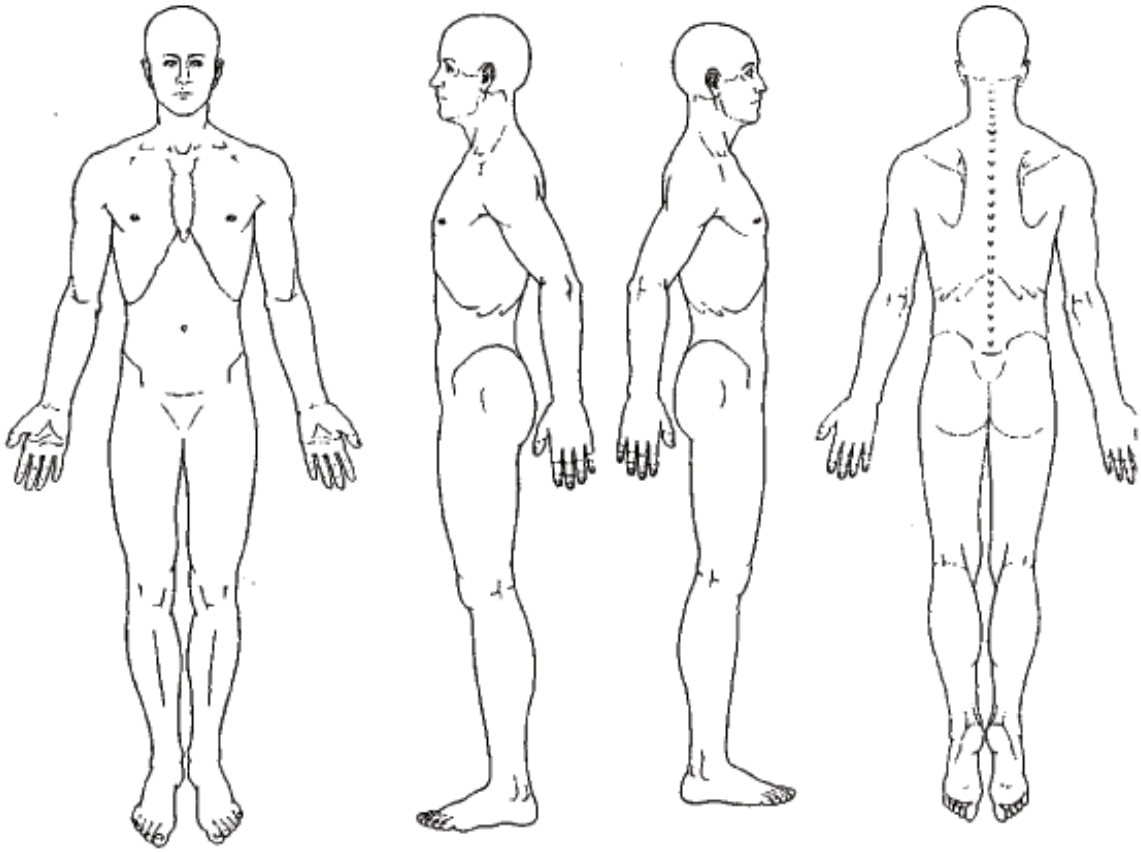
CHIROPRACTIC

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

PATIENT SIGNATURE _____ DATE _____

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HIPPA NOTICE OF PRIVACY PRACTICE

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.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to your to pay your health care bills, to support the operation of the physician's practice, and any other use require by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with third party. For example, we would disclose your (PHI), as necessary, to home health agency that provides care to you. For example, your (PHI) may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your (PHI) will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant (PHI) be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your (PHI) in order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your (PHI) to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your (PHI), as necessary, to contact you to remind you of your appointment.

We may use or disclose your (PHI) in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements Legal Proceedings: Law Enforcement: Coroners,, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker Compensation: Inmates: Required Uses and Disclosures Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance and requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures, Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your (PHI).

You have the right to inspect and copy your (PHI): Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and (PHI) that is subject to law that prohibits access to (PHI).

You have rights to request a restriction of your (PHI): This means you may ask us not to use or disclose any part of your (PHI) for the purpose of treatment, payment or healthcare operations. You may also request that any part of your (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want to restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your (PHI), your (PHI) will not be restricted. You then have the right to use another Health Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have your physician amend your (PHI). If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your (PHI).

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the secretary of health and human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to (PHI). If you have any objections to this form, please as to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature:** _____ **Date:** _____

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