

# PATIENT PERSONAL / CONFIDENTIAL DATA

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_

**How did you learn about this clinic (Google, Instagram, FaceBook, TikTok, Family & Friends, Dr. referral) :** \_\_\_\_\_

Email Address: \_\_\_\_\_

Are you? Married  Divorced  Single

If married: Spouse's / Partner's name \_\_\_\_\_

Do you have kids? Yes  No

If yes, how many and age \_\_\_\_\_

Purpose of this appointment and list your complaints:

\_\_\_\_\_  
\_\_\_\_\_

Date of Injury: \_\_\_\_\_

Time: \_\_\_\_\_ A.M. or P.M.

Location: \_\_\_\_\_

How did the accident occur?  Auto  on the Job  Other, \_\_\_\_\_

Please describe the circumstances and what makes the condition(s) better or worse.

\_\_\_\_\_  
\_\_\_\_\_

Have you seen another Doctor for this condition? Yes or No Doctor's Name: \_\_\_\_\_

Your primary Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**What is your commitment level to improve your health: \_\_\_\_\_%**

## Insurance Information

I understand and agree the health and accident insurance policies are and agreement between the insurance carrier and myself. Furthermore, I understand that this chiropractic Office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office Will be credited to my account upon receipt, However, I clearly understand and agree that all services rendered to me are charged 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 serviced rendered to me will immediately do and payable.

Patient's Signature: \_\_\_\_\_

## Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic service that he/she deems necessary in my case. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications include fractures, disk injuries and stroke. I further authorize him/her to disclose all or any part of my (patients) records to any persons or corporation in which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: \_\_\_\_\_

Patient's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

**MUSCULO SKELETAL  
VASCULAR  
SYSTEM**

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

**GENITO-URINARY  
SYSTEM**

- Bladder
- Excessive Urination
- Scanty urination
- Painful urination
- Discolored urine

**GASTRO-INTESTIONAL  
SYSTEM**

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

**CARDIO-  
SYSTEM**

- Chest Pain
- Pain over heart
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure
- Heart problems
- Lung problems
- Varicose veins

**Nervous System**

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

**Eye, Ear, Nose AND Throat**

- Eye stain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noise
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw pain

**HABITS**

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

**ARE YOU PREGNANT?**

- YES     NO

**Patient's Signature** \_\_\_\_\_

**Patient Accepted?**     Yes     No

**Doctor's Signature** \_\_\_\_\_

## GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain *presently* prevents you from doing what you would normally do. Regarding each category, please indicate the *overall* impact your present pain has on your life, not just when the pain is at the worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW YOUR TYPICAL PAIN LEVEL AFFECTS THESE SIX CATEGORIES OF ACTIVITIES.

1 Family/ at home responsibilities such as yard work, chores around the house or driving the kids to school –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

2 Recreation including hobbies, sports or other leisure activities –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

3 Social activities including parties, theater, concerts, dining – out and attending other social functions –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

4 Employment including volunteer work and homemaking tasks –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

5 Self-care such as taking a shower, driving or getting dressed –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

6 Life-support activities such as eating and sleeping –

0    1    2    3    4    5    6    7    8    9    10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

# TRICARE CHIROPRACTIC, PA

800 W.ARBROOK BLVD., SUITE 110  
ARLINGTON, TX 76015  
817.987.4150  
FAX 817.987.4151

## Notice to Medicare - Part B Beneficiaries Advanced Notice of NON-COVERED Services

Please be aware of the following Medicare Regulations concerning Chiropractic Care.

In accordance with the Medicare Act. Section 1842 (i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary", under Medicare program standards, Medicare will deny payment for that service.

Medicare limits **chiropractic reimbursement to manual manipulation only.**  
**Reimbursement is based on medically necessary correction care only.**  
**Maintenance care is not covered.**

Medicare **DOES NOT** reimburse for charges of exams, x-rays, therapy, supplements or supports from a chiropractor.

X-rays may be required to updated your condition should a new course of treatment be initiated.

Medicare patients will be responsible for deductible amounts, non-covered charges and any denied visit which exceed Medicare Guidelines.

Medicare Supplement Policies and or Major Medical Policies may be affected by Medicare denials.

I have read and understand the limitations for my Medicare coverage and the affects it may have on and supplemental or secondary policies. I am aware that I will be responsible for any charges that Medicare denies or deems over "reasonable and necessary".

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Patient's Signature

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Date

## **Patient Consent / HIPAA Understanding**

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can/will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Tricare Chiropractic has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing any time, except to the extent that you have taken action relying on this consent.

**I understand that by signing below I give my consent to be examined and treated by Dr. Tien Adrian Trinh and any/all other staff of Tricare Chiropractic.** All staff members at Tricare Chiropractic are dedicated to treat me with the utmost respect and professionalism. They will strive to provide me with the best chiropractic care and associated therapies they are able to provide. If I have any comments, complaints, or concerns associated with this facility, I will discuss these issues with the Office Manager on site immediately.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient( IF under 18)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Tricare Chiropractic, P.A.  
800 W Arbrook Blvd. Suite 110  
Arlington, TX 76015**