bloomington wellness center
Twin Cities Scoliosis Center
952.881.2800 office
5143 w 98th st
bloomington, mn 55437
wellbloomington.com

Patient Data Form

Patient Name _____ Preferred Name _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email (for appt. reminders) _____ Referred by _____

Date of Birth_____ Age _____ Gender M / F

Reason for Visit _____

Other providers for this condition? Y / N If so, who? _____ When _____

Emergency Contact _____ Phone _____

Spouse Name _____ Phone _____

Children (name(s) & age(s)) _____

Are you here as the result of an accident? Y / N Accident Date_____

Auto / Work / Other_____ Occupation_____

Employed by _____ Phone _____

Consent to evaluate and treat a minor child (through age 18)

I, _____ , being the parent or legal guardian of _____

hereby grant permission for my child to receive care in our practice.

Signature _____ Date _____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____
Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race: American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)/ Native Hawaiian or Pacific Islander / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

Height: _____ Weight:_____ Blood Pressure:_____ /_____

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HIPPA Privacy Practice Form

To the Patient – Please read the following statements carefully:

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Cory Emberland, DC **Telephone:** 952-881-2800 **Fax:** 612-605-2788
E-mail: info@wellbloomington.com **Address:** 5143 W 98th Street, Bloomington, MN 55437

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, health care and practice operations. I also acknowledge that I have received a copy of, and agree to, Bloomington Wellness Center, PA's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

You are entitled to a copy of this form