Patient Renewal Form

P.O. Box 366 * 794 South Highway 89

Chino Valley, Arizona 86323 928/636-7682

Date ________________________ Pt. Number ___________

Personal Information

Name	Sex	Marital Status	Date of Birth	Home Phone

Mailing Address	City	State	Zip

Physical Address	City	State	Zip

Social Sec. #	Business Phone Number	Company Name	Location

Spouse's First Name	Phone Number	Spouse's Employer	Location

Emergency contact or nearest relative ___________________________________ Phone Number _______________________

1. My present symptoms are 1. _________________________________( ) 2. _______________________________( )

   (pain rating entry) 3. _________________________________( ) 4. _______________________________( )

   Overall Pain Rating 1 2 3 4 5 6 7 8 9 10

2. Recent injuries/falls ____

3. Recent surgery ____

4. Recent accident ____

5. Last physical ____

6. Last adjustment or treatment _______________________________________ With whom ____________________

7. Since I last saw you, I have been seen by Dr. ____

   For ____

8. Do you have insurance? ☐ Yes ☐ No Company ____

   Name of Insured ___________________________ I.D. Number ________________________ Policy/Group Number __________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Bowen Chiropractic & Wellness Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Bowen Chiropractic & Wellness Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's Signature ____ Date ______________________________________

Parent or Guardian's Signature_____________________________________ Print Name _________________________________

Bowen Chiropractic and Wellness Center

Meaningful Use Form

Patient's Name: ______________________________ # _________ Date of Birth: _________

We are now mandated by law to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

R A C E		**E T H N I C I T Y**	**PREFERRED LANGUAGE**
☐ White ☐ Hispanic or Latino	☐ More Than One Race ☐ American Indian	☐ Hispanic or Latino	☐ English
☐ Black or African American	☐ Native Hawaiian ☐ Other Pacific Islander	☐ Not Hispanic or Latino	☐ Spanish
☐ Asian ☐ Alaskan Native	☐ Refused to Report	☐ Refused to Report/Unreported	☐ Other ☐ Refused to Report

I give permission for the office to call all contact numbers with appointment reminders: Yes No

Patient's Email Address: ____

I request my daily records printed each visit ☐ or I will request as needed ☐

I prefer to be contacted by: email ☐regular mail ☐ secure cell phone ☐home phone ☐ text ☐

☐Yes ☐ No Monthly Newsletter emailed and Special Promotions

ARE YOU A SMOKER OR HAVE YOU BEEN A SMOKER? (Please Check the ONE that applies)				
☐ Current Everyday	☐ Current Some	☐ Former Smoker	☐ Never Smoked	☐ Unknown
HOW DID YOU HEAR ABOUT US? (Please Check the ONE that applies)				
☐ Family/Friend Who__________________	☐ Newspaper Name_________________	☐ Other Name________________	☐ Provider List Name________________	☐ Doctor Name_________________
☐ Church	☐ Dex ☐ Action Pages	☐ Mailer	☐ Radio	☐ Sign out front
☐ Seminar Event-Screening	☐ Sports	☐ CDL Physical	☐ Worker's Comp	☐ Internet Search

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

Medication	Milligrams	How and How Often You Taken	Reason for taking	Date Started
_______________	__________	_________________________________	__________________	___________
_______________	__________	_________________________________	__________________	___________
_______________	__________	_________________________________	__________________	___________
_______________	__________	_________________________________	__________________	___________

Please list any known allergies: _____ ____

Reaction: Nausea ___ Vomiting___ Diff. Breathing___ Rash___ Other:______

No Known allergies _____

By signing below, I give permission for you to update my Medication History
By signing I authorize the listed person or persons to be informed of my protected health information.
The person I allow to have access to my records is _________________________________ □ I withdraw consent

*____ __________ ______________________

Signature of Patient, Guardian or Legal Representative Date

FOR OFFICE USE ONLY

Height________ Weight________ Pulse_______ BP_________rt/lt Pulse Ox_____

Initial_____ Date___________