

Priestley Chiropractic

Dr. Walter F. Priestley, DC DICCP

Dr. Christopher Wider, DC

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Who recommended you to our office? _____

Address _____ City _____ State _____ Zip _____

Date of birth _____ Age _____ Marital Status _____ No. Of Children _____

Occupation _____ Employer _____

Emergency Contact and Phone Number _____

Good communication between doctors and patients are essential. We often need to do follow up calls and e-mails for patients in pain. Please provide us with your e-mail address and best phone numbers to reach you. You will be provided with our personal e-mails and cell phone numbers.

E-Mail _____ Cell Phone _____

Home Phone _____ Work Phone _____

Please CIRCLE which is the preferred method of contact: E-mail, Work, Cell or Home Phone.

HEALTH INFORMATION:

What is your major complaint? _____

Other complaints _____

Onset of condition _____

Other doctors who treated this condition _____

Is this injury related to a work or auto injury? _____ Date of Injury _____

What is your primary insurance? _____

I authorize Dr. Priestley's office to obtain necessary medical records related to my above referenced condition.

Signature _____ Date _____

If the patient is a minor, I authorize Dr. Priestley or Dr. Wider to evaluate and treat my child.

Signature of parent/guardian _____ Date _____

PRIMARY CARE PHYSICIAN

In some cases we like to keep your primary care physician informed of your condition and care plan. Unless you have any objections, please be kind enough to include your primary care physician's name and address if known.

Dr. _____ Address _____

PRIVACY NOTICE

Essentially our privacy policy states that we do not give out your medical information to anyone other than your insurance company, yourself, or another doctor involved in your care. If you would like to see the complete detailed policy, you may request a copy at the front desk. If you would like us to release your medical information to someone other than those listed above, we need to be notified verbally or in writing.

If you request any specific restrictions regarding your privacy, please discuss it with the doctor.

By signing below, you acknowledge that you have read and understand the above.

Signature _____ Date _____