Dr. Craig Catalfu
2801 Highway 150, Suite 129H
Hoover, Alabama 35022
Phone: (205) 444-0727 Fax: (205) 444-9499
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New Patient Information

Whom may we thank for referring you to this office? _____

Name: _____ **Date of Birth:** _____ **Social Security Number:** _____ **Gender:** ☐ Male ☐ Female

Email: _____ **Phone:** _____ **Address, City, State, Zip:** _____

Marital Status: ☐ Single ☐ Married ☐ Other **Spouse's Name:** _____ **Spouse's Date of Birth:** _____

Name(s) and Age(s) of Children: _____ **Emergency Contact** *(Name, Phone Number or* ☐ Same as Spouse): _____

Employment: ☐ Ft Employed ☐ Pt Employed ☐ Retired ☐ Ft Student ☐ Pt Student ☐ Other **Employer:** _____ **Occupation:** _____

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ I choose not to specify

Race:
☐ American Indian
☐ Asian
☐ Black/African American
☐ Chinese
☐ Hispanic
☐ Japanese
☐ Korean
☐ Native Hawaiian/other Pacific Island
☐ Vietnamese
☐ White
☐ Other
☐ I choose not to specify

Insurance

Name of Insurance Company: _____ **Subscriber's Name:** _____ **Subscriber's Date of Birth:** _____

Subscriber's Address: _____ **Patient's Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Employee ☐ Other

ID Number: _____ **Group Number:** _____

I authorize the release of any medical information necessary to process my insurance claims and certify that all insurance information given to his office is correct and complete. In addition, I authorize the general release of records, x-rays or reports from physician, hospital or private agency for care and treatment of **(patient's name)** _____ **(date of birth)** _____ to be released to Dr. Craig Catalfu and My Chiropractor.

_____ _____
Signature of Patient or Personal Representative Date

Health History

	Yes	No
Have you ever been adjusted by a chiropractor? If yes, where and how long since your last visit?	☐	☐
Have you had an MRI or x-ray of your area of complaint? If so, when and where?	☐	☐
Have you suffered any trauma such as a motor vehicle accident or fall? If yes, explain.	☐	☐
Have you had any surgeries? If yes, explain.	☐	☐
Are you presently taking any medications? If yes, please list.	☐	☐
Did/do you have any broken bones? If yes, explain.	☐	☐
Do you have any allergies? If yes, explain.	☐	☐
Do you have a pacemaker, insulin pump, or other implanted device? If yes, explain.	☐	☐
Childhood sickness? If yes, explain.	☐	☐
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you eat a healthy diet?	☐	☐
Do you exercise regularly?	☐	☐
Did/do you have occupational, physical and/or mental stress? If yes, explain.	☐	☐
Do you have any hobby/sports injuries?	☐	☐
Other traumas, problems or other information which may be relevant? If yes, explain.	☐	☐

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of or disclosure of my protected health information by Dr. Craig Catalfu for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of My Chiropractor. I understand that diagnosis or treatment of me by Dr. Craig Catalfu may be conditioned upon my consent as evidenced by my signature on this document.

I, the undersigned, a patient of My Chiropractor, hereby authorize Dr. Craig Catalfu D.C. and whomever he may designate as his assistant to administer treatment as is necessary. I also confirm that no guarantee or assurance has been made as to the results that may be obtained.

I understand I have the right to request a restriction as to how my protected health insurance information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. My Chiropractor is not required to agree to the restrictions that I may request. However, if My Chiropractor agrees to a restriction that I request, the restriction is binding on My Chiropractor and Dr. Craig Catalfu.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Craig Catalfu or My Chiropractor has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

We will use a sign-in sheet at our front desk that you will be asked to sign. We may also call you by name in the waiting room, charts may be located at the front desk under observation of the doctor and staff at all times. We may use your protected health information, as necessary, to contact you to remind you of your appointment.

I understand I have a right to review My Chiropractor's Notice of Privacy Practices prior to signing this document. My Chiropractor's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Craig Catalfu. This Notice of Privacy Practices also describes my rights and My Chiropractor's duties with respect to my protected health information.

I will be responsible for all charges incurred by me. Should collection action become necessary, I agree to pay all costs of collection, including reasonable attorney's fees, and waive all rights to claim personal property exempt under the laws of the State if Alabama. I waiver the Statute of Limitations regarding my doctor's right to recover. I understand that the doctor and his staff make no representation as to coverage of my insurance and I do not rely on any insurance representation made to me by the doctor and his staff.

My Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office or visiting the office and requesting a revised copy to be sent to me by mail, be ready for me on my next visit or by obtaining one at the front desk.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____ _____

Witness (My Chiropractor Representative) Date