Vermont Laser Chiropractic, PLC • 85 N. Main St. Ste. 230, WRJ, VT 05001 • 802-295-9583

PATIENT DATA FORM

All information is kept confidential and shared only with other healthcare practitioners when coordinating your care and with your insurance company (worker's comp or personal injury only) if necessary to facilitate communication.

PATIENT INFORMATION

First Name_____ **MI**_____ **Last Name**_____

Mailing Address_____ **Town/State/Zip**_____

Home Phone_____ **Work Phone**_____

Cell Phone_____ **Email**_____

SEX *Male Female* **Social status:** _____ **Date of birth:** _____

WORK STATUS *Employed Student Retired Other*

HISTORY INFORMATION

Is this injury related to an auto accident or employment?_____

Most recent onset or date of initial onset:_____

Area of chief complaint (i.e. lower back)_____

What symptoms are you having?_____

Have you ever been seen by a chiropractor before? Yes/No If yes, when?_____

CONSENT FOR EXAMINATION & TREATMENT

I, the undersigned authorize the performance of an examination which the above doctor may consider necessary or advisable in the course of establishing a differential diagnosis. I authorize the performance of any physiological therapeutics, low-level laser therapy and/or chiropractic manipulative therapy which the treating doctor may consider necessary or advisable in the course of treatment of my condition.

Signed X _____ Date _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to inform you of our privacy practices. They are as follows: 1) We do NOT sell your personal information EVER. 2) Your information is kept private at this location, with our transcriptionist, and is backed up physically and securely online. 3) If we make a referral your consent is implied for us to send your necessary information to the other provider. 4) Any complaints and concerns should be addressed directly to Dr. Shawn McDermott, the compliance officer.

I acknowledge that I have read and consent to Vermont Laser Chiropractic, PLC's Privacy Practices for Protected Health Information as outlined above.

Signed X _____ Date _____