

**GLASGOW CHIROPRACTIC LLC / GLASGOW SPINE AND WELLNESS / WILMINGTON SPINE CENTER**  
**Confidential Patient Health Record**

(Please print in **BLACK** ink only)

**NAME:** \_\_\_\_\_ **Home Phone** (\_\_\_\_) \_\_\_\_\_  
**ADDRESS/PO BOX:** \_\_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **Cell Phone** (\_\_\_\_) \_\_\_\_\_  
**E-Mail** \_\_\_\_\_

\_\_\_\_\_ **Please initial** to receive email and text appointment reminders, office updates and specials.

**Gender:** Male/Female

**Birth Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Occupation** \_\_\_\_\_

**SSN** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Marital Status** \_\_\_\_\_ **# Children** \_\_\_\_\_ **Spouse's Name** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Contact's Phone** (\_\_\_\_) \_\_\_\_\_

**How were you referred to our office?** \_\_\_\_\_

I am seeking:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Chiropractic        | <input type="checkbox"/> Acupuncture               | <input type="checkbox"/> Massage                        | <input type="checkbox"/> Rehabilitation     |
| <input type="checkbox"/> Body Contouring     | <input type="checkbox"/> Scar Removal              | <input type="checkbox"/> Laser Skin Renewal             | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Stretchmark Removal | <input type="checkbox"/> Laser Skin Revitalization | <input type="checkbox"/> Interventional Pain Management |   |

**Primary Physician Name** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**Is your visit due to an accident?** Y N **Date of Injury:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Type of Injury:** \_\_\_\_\_

**Present Complaints:** \_\_\_\_\_

**Other doctors seen for this problem:** \_\_\_\_\_

**Significant Health History**

\_\_\_\_\_  
\_\_\_\_\_

**CONSENT TO TREAT:** My signature stands proof that I give Glasgow Chiropractic LLC my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

**Patient Print Name** \_\_\_\_\_

**X Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**GLASGOW CHIROPRACTIC LLC / GLASGOW SPINE AND WELLNESS / WILMINGTON SPINE CENTER**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Please initial by the following:**

I acknowledge payment is expected at the time of service.

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**CHIROHEALTH USA Acknowledgement of Receipt of Notice of Privacy Practices**

We are required to provide you with a copy of our Notice of Privacy Practices from ChiroHealth USA, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

\_\_\_\_\_

**Patient Signature/Legal Representative/Guardian**

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**Acknowledgement of Receipt of Notice of Privacy Practices**

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**Please initial by the following:**

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Glasgow Chiropractic L.L.C..

I understand that the Notice describes the uses and disclosures of my protected health information by Glasgow Chiropractic L.L.C. and informs me of my rights with respect to my protected health information.

\_\_\_\_\_

**Patient Signature/Legal Representative/Guardian**

\_\_\_\_\_  
**Printed Name/Legal Representative & Relationship**

**DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_