Reservoir Chiropractic, Inc.

This is a summary of the following pages of our Privacy Notice. Please read this and following instructions. Feel free to take the Privacy Notice home with you.

Here is how we protect your personal details:

1. We will make every effort to protect your personal information. In signing below, I acknowledge I have received a Privacy Notice from Reservoir Chiropractic, which is also displayed on bulletin board:

   _____ Date: _____
   Patient Signature

2. We will never profit by selling your name, or using it in any way inappropriately.

3. We would like to send you information occasionally in the mail or on email. This will be approximately one to two times a month,, and any other special notices re: office happenings. You may opt out of this now by stating it here. Otherwise, we will assume you authorize us to communicate with you.
   I wish to opt out of any mail contact, including email: Please sign here:

   _____
   ** I must inform you that if you sign here, you will receive nothing from our office in the mail. We cannot pick and choose which mail you get and which you don't, due to restrictions in our office software.

4. Signing this is voluntary, and if you do not, you will still receive the best health care possible by our staff. You may revoke the authorization at any time in writing to Dr. Joanie Winstead. You may request a copy of this signed form at any time.

I understand this form was completely filled in as I wanted it prior to signing. All my questions were answered to my satisfaction and I understand this form and all of its contents. I received a copy of the office's privacy notice.

*If coverage cannot be verified on the date of service payment in full may be required. **Also a $20.00 Non-Cancellation Fee will be charged if you miss an appointment or do not cancel 12 hours prior to appointment.** I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Reservoir Chiropractic is filing my insurance as a courtesy; and insurance is no guarantee of payment, as stated by the insurance companies when we check benefits. All charges due must be paid at the time of service unless payment arrangements are made. **I understand that my insurance company may not cover fully (or at all) my bills for services provided, and that I will be responsible for payment of all charges. In the event Reservoir Chiropractic refers my account to an attorney to collect an unpaid balance, I agree to pay reasonable attorney's fees incurred in the collection of the unpaid balance.** Reservoir Chiropractic will do our best to keep track, but is NOT responsible for counting the allowable NUMBER of VISITS or MAXIMUM DOLLAR benefits per calendar year. I understand this is shown on the EOB (Explanation of Benefits) that I receive from my insurance company after each visit.

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance Company
directly to Reservoir Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize Dr. Joanie Winstead, and all associates, and assistants to render Chiropractic services as they deem necessary.

Patient Signature: _____ Date:___ /_____/_____
(or legal Guardian, parent, attorney)

Print Name:_____

Office Staff Witness: _____ Patient's Clinic I.D._____

Reservoir Chiropractic
1090 Lake Village Circle
Brandon MS 39047
601-919-8800 Fax 601-919-8808

Patient Name: _____ Today's Date: ____/____/____
First M.I. Last

SSN# _____ Birth Date: ____/____/____ Age: _____ Gender: F M

Marital Status: □ Married □ Divorced □ Widowed □ Single Number of children? _____

CURRENT ADDRESS:
Street _____City _____ State _____ Zip _____

Home Phone (____) _____ Cell (____) _____ Work (____) _____ Ext _____

Primary Contact: □ Home □Cell □Work

Email _____

OTHER ADDRESS FOR RESIDENCE OR BILLING PURPOSES (e.g., parents, guardian, attorney):

Street_____ City _____ State _____ Zip _____

Home Phone (_____) _____

Is this a motor vehicle accident or work related injury? YES NO

Your Occupation _____ Employer _____

Work Address _____ City_____ State_____ Zip _____

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Work Phone (_____) _____ Contact Phone (_____)_____

Emergency Contact: _____ Phone: (____) _____Relationship:_____

Are there any person's you wish to give us permission to share your health information with? YES NO Initials:_____
Name_____ Phone (____)_____

How did you hear about us or referral name? _____

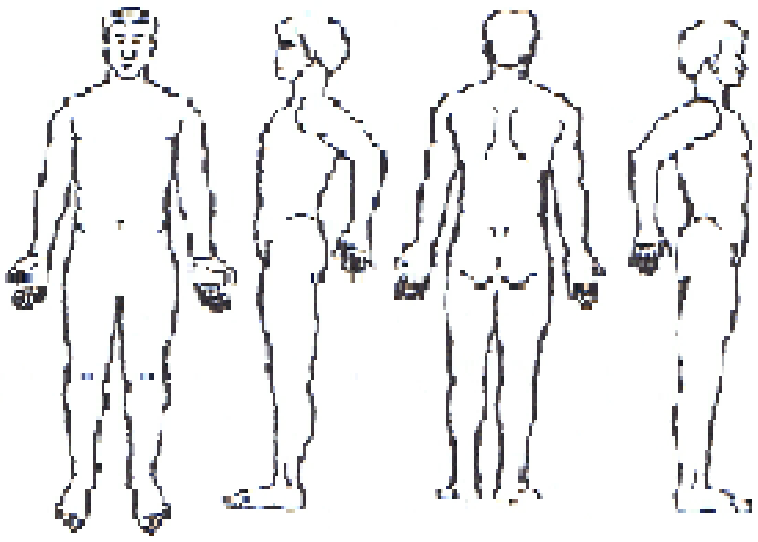
Patient Signature _____ Date ____/_____/_____ Patient I.D._____

Symptoms

Major Complaint:_____
Start date of symptoms?_____ Are symptoms/condition getting worse? Yes No
What activities aggravate it?_____What relieves it?_____
Rate the severity of pain (0-none to 10-severe): BODY AREA 1:_____ 0 1 2 3 4 5 6 7 8 9 10
BODY AREA 2:_____ 0 1 2 3 4 5 6 7 8 9 10
OTHER:_____ 0 1 2 3 4 5 6 7 8 9 10
Frequency of pain? constant/ frequent/ intermittent/ occasional/ infrequent/ none/ other_____
What activities are difficult? Sitting Standing Lying Down Bending Walking Other_____
Description of the pain: Sharp Dull Aching Burning Shooting Throbbing Numbness Tingling Stiffness
Cramping Swelling Other_____
Have you ever had the same or similar condition/symptoms before? Yes No If yes, when?_____
Have you already received other treatment for your current condition?_____
Please list any other healthcare providers that you are currently under their care:
Provider Name_____Date of last visit_____/_____/_____
Provider Name_____Date of last visit_____/_____/_____
Provider Name_____Date of last visit_____/_____/_____
Have you seen a chiropractor in the past? Yes No If yes, who?_____

Body Chart

Shade your symptom area. Place an "S" for sharp pain, a "T" for tingling, a "N" for numbness and a "D" for dull pain:



What desired activities are you unable to do because of your condition or pain?

_____
_____
_____
_____
_____
_____
_____

Daily Habits

Do you exercise regularly? Yes No Describe?_____
Do you smoke or use tobacco products? Yes No How much per day?_____
How much alcohol do you consume on a weekly basis?_____
How much coffee, tea, or other caffeinated beverages do you consume per day?_____

Patient Name:_____Date:_____/_____/_____Patient I.D._____

Health and Medical History-*Circle all the present conditions, and underline the past conditions. List approximate date condition began.*

Acid Reflux Constipation Headache Migraines Low Blood Pressure

AIDS/HIV	Depression	Heart Disease	Memory Loss	High Cholesterol	
Allergies	Diabetes	Hepatitis	Miscarriage	Psychiatric care	
Anemia	Diarrhea	Herniated Disc	Mononucleosis	Rheumatoid Arthritis	
Anorexia	Difficulty Sleeping	Herpes	Multiple Sclerosis	Stroke	
Appendicitis	Dizziness	High Blood Pressure	Muscle Weakness	Seizures	
Asthma	Emphysema	Insomnia	Mumps	Shortness of Breath	
Bloating	Epilepsy	Irritability	Osteoporosis	Nausea	
Bronchitis	Fainting	Kidney Disease	Osteopenia	Vertigo	
Bulimia	Fatigue	Liver Disease	Pacemaker	Nervousness/Anxiety	
Cancer	Fever	Light Sensitivity	Indigestion	Suicide Attempt	
Cataracts	Fractures	Loss of Smell	Pneumonia	Scoliosis	
Chicken Pox	Glaucoma	Loss of Libido	Parkinson's	Thyroid Disorder	
Cold Sweats	Goiter	Low Energy	Polio	Tonsillitis	
Cold Feet or Hands	Gonorrhea	Measles	Prostate Disorder	Tuberculosis	
TMJ Problems	Ulcers	Whooping Cough	Vaginal Infection	Prosthesis	

Other_____

Women only: Are you pregnant? No Yes
Number of weeks? _____
Nursing: No Yes

List Family history of illnesses known:
Mother:
Father:
Grandparents:
Siblings:
Aunts/Uncles:

Have you had any of the following vaccines:

Shingles	YES	NO
Pneumonia	YES	NO
Gardasil	YES	NO
Flu	YES	NO
Covid 19	YES	NO

List any surgeries or procedures which you have had:
_____Date_____/_____/_____
_____Date_____/_____/_____
_____Date_____/_____/_____

List any allergies you have:_____
List any medications or nutritional supplements you are currently taking:_____
_____
_____

Patient Name:_____Date:_____/_____/_____Patient I.D._____