

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone # (H) _____ (W) _____ (cell) _____

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)
AND DRIVER'S LICENSE**

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Wulf Clinic Healthcare, PA., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? Doctors Name: _____

Address: _____ City _____ Phone: _____

Please check to indicate if you are currently experiencing any of the following conditions:

- Neck Pain/Stiffness
- Pins/Needles in Arms
- Light Bothers Eyes
- Sudden Weight Loss
- Nausea
- Back Pain/Stiffness
- Pins/Needles in Legs
- Depression
- Loss of Taste
- Cold Feet
- Arm/Hand Pain
- Fatigue
- Nervousness
- Loss of Memory
- Chest Pain
- Leg/Knee Pain
- Sleeping Difficulties
- Tension
- Jaw Problems
- Fever
- Headaches
- Loss of Smell
- Cold Sweats
- Constipation
- Fainting
- Dizziness
- Allergies
- Stomach Problems
- Shortness of Breath
- Asthma
- Blurred Vision
- Night Pain
- Bowel/Bladder Changes

Please check to indicate if you have ever had any of the following:

- Aids/HIV
- Cancer
- Hepatitis
- Osteoporosis
- Stroke
- Alcoholism
- Cataracts
- Hernia
- Pacemaker
- Suicide Attempt
- Allergy Shots
- Chemical Dependency
- Herniated Disc
- Parkinson's Disease
- Thyroid Problems
- Anemia
- Chicken Pox
- Herpes
- Pinched Nerve
- Tonsillitis
- Anorexia
- Diabetes
- High Cholesterol
- Pneumonia
- Tuberculosis
- Appendicitis
- Emphysema
- Kidney Disease
- Polio
- Tumors/Growths
- Arthritis
- Epilepsy
- Liver Disease
- Prostate Problems
- Typhoid Fever
- Asthma
- Fractures
- Measles
- Prosthesis
- Ulcers
- Bleeding Disorders
- Glaucoma
- Migraines
- Psychiatric Care
- Vaginal Infections
- Breast Lump
- Goiter
- Miscarriage
- Rheumatoid Arthritis
- Venereal Disease
- Bronchitis
- Gonorrhea
- Mononucleosis
- Rheumatic Fever
- Whooping Cough
- Bulimia
- Gout
- Multiple Sclerosis
- Scarlet Fever
- Mumps
- Other _____

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- Heart Disease _____
- Diabetes _____
- Cancer _____
- Arthritis _____
- Other _____

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do your legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? _____
_____ | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? _____
_____ | NO | YES |
| 13. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? _____
_____ | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? _____
_____ | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

Patient's Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

Authorization for Disclosure – General Consent Form

I, _____
Name Date of Birth SS#

Authorize **Any Medical Provider** to disclose to **WULF CLINIC HEALTHCARE, PA**, or authorized representative, providing ID verification, the following information from my client file or records:

1. Client information and services provided (types and dates only).
2. Summary of Assessment and Treatment.
3. Physical examinations or other medical information.
4. Any Radiology reports and films needed for diagnosing or treating.

The purpose for disclosure is records review. The consent to disclose information from my records may be revoked by me or anyone holding power of attorney if such is among the enumerated powers, at any time, except to the extent that the consent has been relied on and action has been taken thereon.

This consent becomes effective on the date that it is signed. This information will be released ONLY to the person or organization above named. It will not be disseminated to anyone, for any purpose, other than the one specified.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Tolling Agreement

The undersigned debtor(s) who is/are indebted to Wulf Clinic Healthcare, PA, dba The Wulf Clinic (Dr. Todd Wulf) (Creditor) hereby agree that the applicable statute of limitations pertaining to all accounts or debts owed Creditor, or either of them, shall be tolled from the date hereinafter specified until thirty (30) days after the date that written notice shall be received by Dr. Todd Wulf that this agreement shall cease. Such notice to Dr. Todd Wulf shall identify all debtors on such accounts and shall be sent to Dr. Todd Wulf, 593 Horsebarn Rd., Suite 101, Rogers, AR 72758 via certified mail.

(Patient's Name) Debtor

Effective Date: _____, 2011

Wulf Clinic Healthcare, PA
593 Horsebarn Rd., Suite 101
Rogers, AR 72758
Office: 479 271-9191 Fax: 479-271-9196

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Wulf Clinic Healthcare, PA
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can
request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Wulf Clinic Healthcare, PA to leave reminder
messages on my answering machine or with another person in my home. I may make a request of an
alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I
may speak with the Compliance Officer, about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date