ZOELLER & ZOELLER, D.C.P.A
2900 Atwood , Topeka , Ks. 66614
785-272-5844 / fax 785-272-5846

PATIENT HISTORY : (please circle or check for each that applies)

Last name:_____sex : male / female Age: _____

First name:_____Middle:_____ Marital status: M S D W

Address:_____

Zip code: _____ City: _____ State:_____

D.O.B. __ __/__ __ / _____ Social Security #: __ __ __ - __ __ __ - __ __ __ __

Home # : __ __ __-__ __ __-__ __ __ __ Office # : __ __ __-__ __ __-__ __ __ __

Cell # : __ __ __-__ __ __-__ __ __ __ E-Mail :_____@_____

Occupation:_____Employer:_____

Number of children & Ages : _____

In case of emergency contact:_____# __ __ __ - __ __ __ __

Spouses name (Parent if minor): _____

INSURANCE INFORMATION: Subscribers name : _____

Spouses D.O.B if primary carrier : __ __ / __ __ / __ __ __ __

Spouses Employer:_____

ID # _____ Group # _____Policy # _____

I hereby authorize the _____ to pay directly to the office
(your insurance company name)
of Dr. Zoeller & Zoeller the expense benefits allowable. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Signature : _____ Date __ __/__ __/ __ __ __ __

Parents signature if minor : _____ Date __ __/__ __/__ __ __ __

Symptoms and Present State of Health:

Present Complaint / Reason for Seeking Care in this office? _____

_____

Pain or Problem started on : _____
(please circle each of the following)

Pains are : **Sharp , Dull/Ache, Constant , Intermittent , other:**_____

Does the pain shoot, radiate or travel in your body if so please describe: _____

_____

Are you experiencing numbness of tingling in any are of your body ? Yes or No

If yes please describe:_____

Since it begun is your pain / tingling /numbness : **Same , Better , Worse,**

What activities aggravate your condition ? _____

What activities lessen your condition / pain ? _____

Is this condition worse at certain times of the day? _____

Is this condition interfering with : (circle) **Work , Sleep, Routine, Other:** _____

Is this condition getting progressively worse ? _____

Have you seen other Doctors for this condition ? _____

Have you used any home remedies / over the counter if so list: _____

Are you under medical care for any condition? If so please list: _____

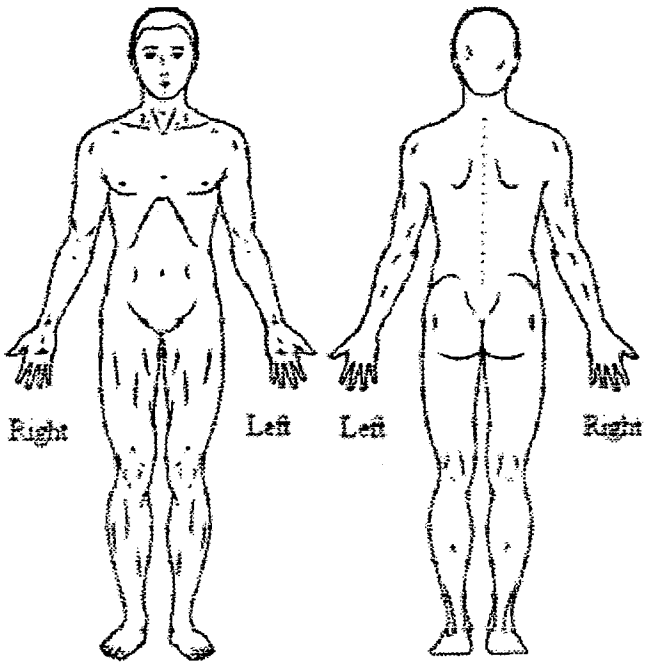
_____

Have you had surgery ? If so please list :_____

Please list any medications you are currently taking: _____

_____
(if you have a list we will kindly make a copy and put in your file)

Please Circle your level of pain .
(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Stiff Neck	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke	other: _____
Father's side	O	O	O	O	O	
Mother's side	O	O	O	O	O	other: _____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

SHORT FORM
Privacy Consent Form / Required by Federal HIPAA Law #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship
- The information that you provide us is kept in the strictest of confidence
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:
  1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
  2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services
  3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please note:
We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Rights Under HIPAA LAW #101-191

1. You have the right to request that we do not disclose your private health information to specific Individuals, companies or organizations under the following circumstances:
   a. All requests must be in writing
   b. By law we are not required to agree with your restrictions, HOWEVER,
   c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your authorization under certain conditions:
   a. It must be in writing.
   b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
   c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records.

	Zoeller & Zoeller, D.C.P.A.
Printed Patient Name	Printed Authorized Provider Name
Signature Date	Signature Date

Authorization for Appointment Reminders and Health Care Information

There may be times when the doctor or members of the doctors team may need to use your private health information such as your name, address, phone number in order to contact you in regards to appointment reminders, requested information about alternative treatment or other health related information. If you are not at home to receive this information we would like to leave you a message. By signing this form you are giving us authorization to contact you and/or leave you a message.

Signature: _____ Date: _____

Zoeller & Zoeller, D.C.P.A.
2900 SW Atwood
Topeka, Ks. 66614-2838

Consent for purpose of treatment, payment and health care operations:

I consent to the use or disclosure of my protected health information by Zoeller & Zoeller, D.C.P.A. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mark Zoeller, D.C. or Ronald Zoeller, D.C.

I understand that diagnosis or treatment of me by Zoeller & Zoeller, D.C. P.A. may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Zoeller & Zoeller, D.C.P.A. is not required to agree to the restrictions that I may request. However, if Mark Zoeller, D.C. or Ronald Zoeller D.C. agrees to a restriction that I request, the restriction is binding on Mark Zoeller, D.C. or Ronald Zoeller, D.C. and Zoeller & Zoeller, D.C.P.A.

I have the right to revoke this consent in writing at any time, except to the extent that Zoeller & Zoeller, D.C.P.A. or Mark Zoeller, D.C. or Ronald Zoeller, D.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collect from me and created or received by my physician, another health care provider, health plan, my employer or a mental health 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. I understand I have the right to review Dr.'s Zoeller & Zoeller, D.C.P.A. Notice of Privacy practices prior to signing this document.

The Notice of Privacy Practices describes the types of 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.

Mark Zoeller, D.C. & Ronald Zoeller, D.C. reserves the right to change the privacy practices that are described in the Notice of Privacy practices at any time.

I may obtain a revised copy of the Privacy Practices by calling the office of Zoeller & Zoeller, D.C.P.A. and picking up a copy, or a mailed copy for a postage fee.

_____
Signature of Patient or Personal Representative

_____ _____/_____/_____
Name of Patient or Personal Representative Date