WELCOME

ABOUT YOU

Date: _____/_____/_____

Patient Name: ____
LAST FIRST MI

What do you prefer to be called? ______________________ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____

Mailing Address: ____

____
CITY STATE ZIP

Phone #: ______________________ Email: ______________________

Referred by: ____

Medical Doctor: ____

Emergency contact name: ______________________ Phone #: ______________________

Employer: ____

Occupation: ____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____

REASON FOR VISIT

The reason for this visit is a result of (please circle): wellness, work, sports, auto, trauma or chronic.

(Explain what happened): ____

____

Please describe the pain & its location: ____

____

When did condition begin? _____/_____/_____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with you (please circle): work, sleep, or daily routine.

If so, please explain: ____

Have you has this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: ____

Have you ben treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? ____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? ______________________ Phone # ______________________

PLEASE CONTINUE ON BACK

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood ☐ Tranquilizers ☐ Insulin

☐ Other(s) ____________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones/Joints	**Y N** Arthritis

Please list any serious medical condition(s) you have or ever had: ____________________

____

Please list anything you may be allergic to: ____________________

____

List previous surgeries/treatments with dates: ____________________

____

List any **past** serious accidents with dates: ____________________

____

Family Health History: ____________________

____

Do you: Take Supplements or Vitamins? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Since: _____/_____/_____

Do you smoke? ☐ Yes ☐ No How much? _____ How Long? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, how long? _____ Nursing? ☐ Yes ☐ No

PAIN CHART

ABOUT YOU

Name: ____

What is your current weight: _____lbs., and height: _____Ft. _____In.

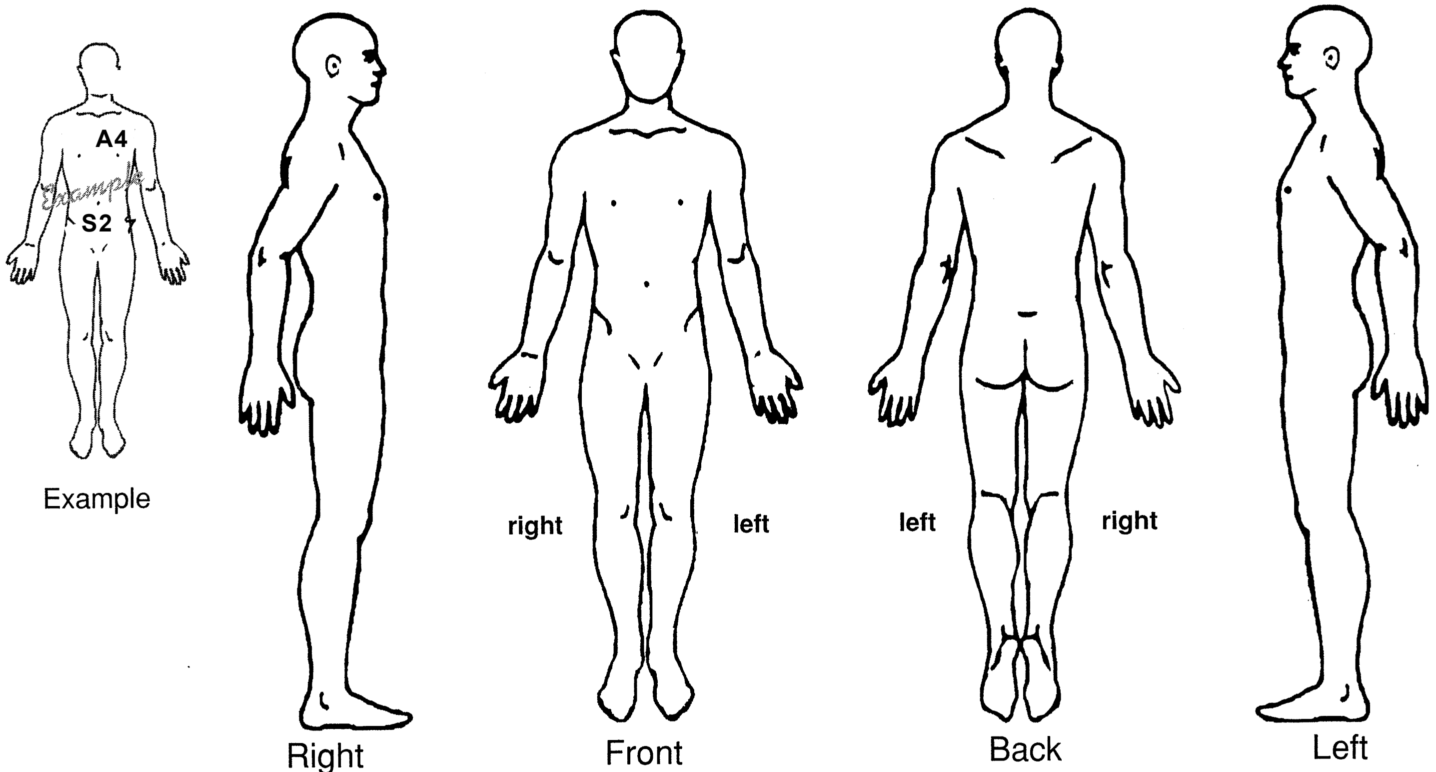
Signature: ____ Date: _____/_____/_____

SHOW US WHERE IT HURTS

Please mark all areas of discomfort with the appropriate symbol and number:

Description ⇨	Numbness	Pins & Needles	Aching	Stabbing
Symbol ⇨	N	P	A	S

Indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).



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OUR FINANCIAL POLICY

We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT TIME OF SERVICES RENDERED. Should the patient terminate care, any fees for services become the full responsibility of the patient and will become immediately due and payable, unless other arrangements are made.

MINOR ACCOMPANIED BY AN ADULT. The adult accompanying a minor or his/her (or guardians), are responsible for full payment at time of service.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract and will handle your claims according to our agreement with the insurance company, if one exists.) We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc.; other than to supply factual information as necessary. *You are responsible for the timely payment of your account.* Should the patient terminate care and treatment, any fees for professional service will become immediately due and payable.

MEDICARE BENEFITS

Medicare does cover chiropractic care but with limitations.
Medicare requires current x-rays of your spine, and the x-rays must show a subluxation.
Medicare does not cover the cost of x-rays although Medicare requires them. Also not covered are any supports, supplements, examinations, or other services offered in this office.
The only service covered by Medicare is manual manipulation of the spine. Under some circumstances and with some Medicare Carriers, these manipulations are limited to twelve (12) per year. Your condition may require, in our judgments, more treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be then sent for review. We cannot guarantee or predict what the review board will decide in your case.

I hereby authorize **ARNOLD CHIROPRACTIC CENTER** to release any information to my insurance company or attorney acquired in the course of my examinations or treatment. I understand that a photocopy of the above assignment and authorization will be deemed as valid as the original.

I have read and understand the above statements.

Signature :____ **Date :**______________________

Patient or Parent/Guardian

HIPPA AUTHORIZATION AND CONSENT

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that is information serves as:

• a basis for planning my care and treatment;
• a means of communication among the health professionals who may contribute to my healthcare;
• a source of information for applying my diagnosis information to my bill; a means by which a third-party payer can verify that services billed were actually provided;
• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

Patient Name: ______________________________________

Signature: ______________________________________

Date: ______________________________________