

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. _____
Last Legal First Middle Initial
Name you prefer to be called (nickname): _____ Social Security #: _____
Phone #:() _____ Fax #:() _____ Cell #:() _____
E-mail: _____ Driver's License #: _____
Address: _____ City: _____ State: ___ Zip: _____
Age: _____ Birth Date: _____ Sex: _____ Patient's Employer: _____
Work Address: _____ City: _____ State: ___ Zip: _____
Phone #: () _____ Ext: _____ Occupation: _____
Marital Status: _____ Spouse's Name: _____
Emergency Contact: _____ Relationship: _____ Phone: () _____

Note: Fill out this section only if insured is different than patient. Name of Insured: _____
Relationship to insured: (please circle one): spouse/domestic partner child other: _____
Address: _____ City: _____ State: ___ Zip: _____
Social Security #: _____ Phone #:() _____ Birth Date: _____
Insured's Employer (if different from patient): _____ Phone #:() _____
Work Address: _____ City: _____ State: ___ Zip: _____

PERSONAL HEALTH HISTORY

Have you seen Dr. Steinys for anything before? No/Yes, explain: _____
Have you ever been to chiropractor before? No/Yes, what for? _____
Who referred you to our practice? Person: _____ Advertisement: _____
Are you, or might you be pregnant? No/Yes Anticipated Due Date: _____ Do you have a pacemaker? No/Yes
What do you hope to do better or enjoy more when you regain your health? _____

When was your last physical exam? _____ Results: _____

Date, and results, if known, of any recent tests: cholesterol: _____ other: _____
Please list all current medications, vitamin/mineral supplements, herbs, including dosage: _____

List any known allergies: _____
If you smoke or have ever smoked, describe how much, and for how long: _____
Describe your recreational drug use: _____ typical alcohol intake (#of drinks per day/per week): _____
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____

Please list and describe all significant previous surgeries: _____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session: _____

CHIEF COMPLAINT

Name: _____ **Date:** _____ **Condition #:** _____ (use separate form for each condition)

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? Yes/No **Please Initial:** _____ If yes, please fill out accident-specific form at the front desk
2. Please describe the nature of your condition at this time: _____

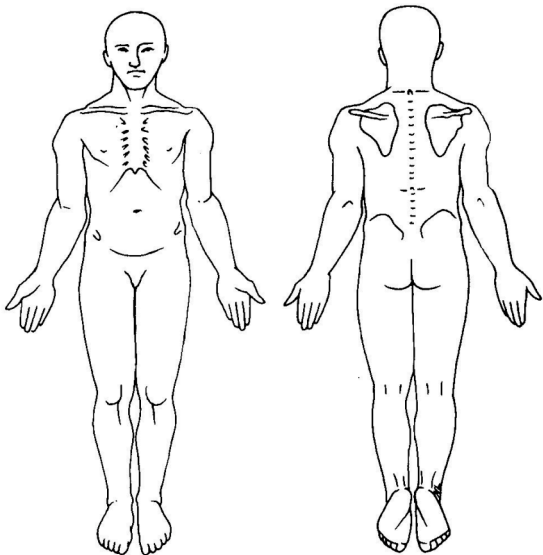
3. When did your condition first begin? Year: _____ Month: _____ Day/Date: _____ Time: _____
4. Cause of condition (circle all that apply & explain): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain: _____

5. Have you had anything like this before? No/Yes: when?: _____
6. How often does the problem re-occur?: _____
7. Is the pain (circle): constant, on & off, usually lasting: ___minutes ___hours ___days ___weeks other: _____
8. Lately, has the pain been(circle): getting better getting worse staying about the same
9. Does the pain radiate?, to where: _____
10. What makes it feel better? _____
11. What makes it feel worse? _____
12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment and results: _____

13. At what time of day (AM, PM) or week (M-F/wknd) is your pain worst? _____
14. In what setting (home, recreation, work) is your pain worst? _____
15. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse? _____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
 (1=minimal pain; 10=worst pain imaginable)

<u>PAIN CURRENTLY</u>										
1	2	3	4	5	6	7	8	9	10	
<u>PAIN AT ITS WORST</u>										
1	2	3	4	5	6	7	8	9	10	
<u>PAIN TYPICALLY</u>										
1	2	3	4	5	6	7	8	9	10	

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings: _____

REVIEW OF SYSTEMS

Please write a **letter** in the spaces below: **H.**presently have **P.**previously had **A.**related to accident

GENERAL

- _____ Frequent or recurring Chills
- _____ Convulsions
- _____ Frequent or recurring Dizziness
- _____ Frequent or recurring Fainting
- _____ Frequent or recurring Fatigue
- _____ Frequent or recurring Fever
- _____ Headache
- _____ Frequent or recurring Sleep loss
- _____ Recent Weight Change
- _____ High Cholesterol
- _____ Cancer
- _____ Diabetes
- _____ Anxiety
- _____ Depression
- _____ Frequent or recurring Sweats
- _____ Frequent/recurring hives/rashes
- _____ Frequent/recurring cold sores
- _____ Anemia

GENITO-URINARY/ENDOCRINE

- _____ Bedwetting
- _____ Frequent urination
- _____ Urinary tract infections
- _____ Painful urination
- _____ Painful menstruation
- _____ Prostate trouble
- _____ Loss of bowel/bladder control
- _____ Vaginal burning/itching
- _____ Breast Lump/Pain
- _____ Sexually Transmitted Infection
- _____ Blood in urine
- _____ Thyroid problems
- _____ Kidney stones
- _____ Irregular menstrual cycle
- _____ Hot flashes
- _____ Hot Flashes
- _____ Sexual difficulties

RESPIRATORY

- _____ Spitting up phlegm
- _____ Chest pain
- _____ Spitting up blood
- _____ Difficulty breathing
- _____ Asthma
- _____ Wheezing
- _____ Chronic cough

Date Last Period Began _____
Date of last PAP test _____

GASTROINTESTINAL

- _____ Bloating, belching, gas
- _____ Pain over stomach
- _____ Esophageal reflux
- _____ Vomiting
- _____ Nausea
- _____ Ulcer
- _____ Hernia
- _____ Difficulty Swallowing
- _____ Frequent heartburn
- _____ Diarrhea
- _____ Constipation
- _____ Poor appetite

CARDIOVASCULAR

- _____ Hardening of arteries
- _____ High blood pressure
- _____ Varicose Veins
- _____ Pain over heart
- _____ Poor circulation
- _____ Rapid heart beat
- _____ Swelling of ankles

EYES, EARS, NOSE, THROAT

- _____ Frequent/recurring sore throat
- _____ Deafness
- _____ Dental problems
- _____ Ear problems
- _____ Sinus problems
- _____ Frequent/recurring nose bleeds
- _____ Vision problems

MUSCULOSKELETAL - pain or numbness in:

- _____ Low Back
- _____ Neck
- _____ Upper Back
- _____ Mid Back
- _____ Between Shoulder Blades
- _____ Shoulder Blade: R/L both
- _____ Shoulder: R/L both
- _____ Arm: R/L both
- _____ Elbow: R/L both
- _____ Hand: R/L both
- _____ Leg: R/L both
- _____ Hip: R/L both
- _____ Knee: R/L both
- _____ Ankle: R/L both
- _____ Foot: R/L both
- _____ Spinal curvature
- _____ Other: _____

NUTRITION

Height: _____ Present Weight: _____ Weight one year ago: _____ Preferred Weight: _____

Please indicate which you eat on a typical day: { } Breakfast { } Lunch { } Dinner # of snacks/day: _____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

- | | | | |
|--------------------|---------------------------|--|---------------------------------|
| _____ Eggs | _____ Red Meat | _____ Fruits | Fats/Oils: |
| _____ Cheese | _____ Pork | _____ Vegetables | _____ Canola _____ Corn |
| _____ Skim Milk | _____ Fish | _____ Desserts | _____ Olive _____ Peanut |
| _____ 1% Milk | _____ Ham | _____ Grains, Rice, Pasta, Cereal, Bread | _____ Safflower _____ Sunflower |
| _____ 2% Milk | _____ Beans | _____ Butter | _____ Other: _____ |
| _____ Whole Milk | _____ Chicken/Turkey | _____ Margarine | _____ Other: _____ |
| _____ Yogurt | _____ Tofu/Soy | _____ Nuts/Seeds/Peanut Butter | _____ Bacon/Hot Dogs, etc. |
| _____ Other: _____ | _____ Sausage/Lunch Meats | _____ Other: _____ | _____ Spicy Foods |

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

- | | | | |
|----------------------------|---------------------------|--------------------------------------|--------------------|
| _____ Caffeinated Coffee | _____ Regular Soft Drinks | _____ Water | _____ Other: _____ |
| _____ Decaffeinated Coffee | _____ Diet Soft Drinks | _____ Fruit Juices | _____ Other: _____ |
| _____ Regular Tea | _____ Herbal Tea | _____ Sports Drinks (i.e., Gatorade) | _____ Other: _____ |

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet: _____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____

FINANCIAL POLICY

Patient Name: _____ **Social Security #:** _____
Last Legal First Middle Initial

Name of Insured: _____ Social Security #: _____
(if different from patient) Last Legal First Middle Initial

Primary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____

ID#: _____ **Policy/Group#:** _____

Secondary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____

ID#: _____ **Policy/Group#:** _____

➔ **If you would like our office to bill your insurance, please provide your credit card information below. Your card will be kept on file but not charged without prior notification. Without a card on file, payment is due in full at the time services are rendered.**

CREDIT CARD #: _____ **EXPIRATION DATE:** _____

CARDHOLDER SIGNATURE: _____ **DATE:** _____

➔ **We offer the following billing options. Please *initial* the one that applies to you & sign at the bottom of the page. Also, to avoid a missed appointment fee of \$50.00, kindly give at least 24-hour notice if you need to reschedule an appointment.**

_____ **Private Pay:** I will pay for all services, as they are rendered, and submit my own insurance claims.

_____ **PPO/Preferred Provider Organization:** You are in my PPO network. I am responsible for any co-payment, deductible, and non-covered services, according to my plan. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.

_____ **Group/Health:** I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.

I understand that if my insurance company does not pay the balance within 60 days of submission, I am responsible for the entire balance overdue.

_____ **HMO/POS:** My primary care physician (PCP) has agreed to authorize a referral to your office. It is my responsibility to make sure that the number of visits authorized remain current. I understand that I am responsible for, and will pay, whatever co-payment and non-covered services that my plan sets forth.

_____ **Medicare:** I am a Medicare participant and I understand that Medicare only pays for spinal manipulation procedures at 80% of their approved amount, and only after my yearly deductible has been met. Your office will bill Medicare directly. Medicare should then reimburse your office at 80% of the spinal manipulation fee. Any supplemental policy should also reimburse your office, according to the benefits allowed by that policy. If I have a supplemental policy, it may cover the 20% of the portion of the spinal manipulation fee not paid by Medicare, and/or some percentage of any other procedures (besides spinal manipulation) not covered by Medicare. Regardless of my insurance coverage, I understand that I am ultimately personally responsible for the balance of all charges for all services rendered and supplies purchased.

_____ **Worker's Compensation:** I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (ie, accident report, etc.). I understand that it is my right to have any bills incurred as a result of a work-related accident paid for. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.

_____ **Auto Accident/Personal Injury:** I was involved in an automobile accident/personal injury and would like to have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. If the first insurance payment is not received within 45 days of my first date of service, I agree to pay \$100.00 per month while your office awaits final payment. I will be promptly reimbursed should any overpayment occur on my account. I understand that regardless of payment arrangements, I am personally responsible for the entire balance within 90 days of completion of treatment.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF INSURED(if different from patient)/GUARDIAN: _____ **DATE:** _____

ASSIGNMENT (of benefits to doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Core Chiropractic Health Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF INSURED(if different from patient)/GUARDIAN: _____ **DATE:** _____

**WE TYPICALLY SUBMIT AN INITIAL REPORT TO YOUR PRIMARY CARE DOCTOR.
PLEASE PROVIDE US WITH THE NECESSARY INFORMATION:**

Primary care Dr: _____ **Tel:** _____ **Address:** _____