NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: ______________________________

Name: (First)______________________________ (Last)______________________________________ (M.I.)_________

Home Address____

City____ State______________________ Zip _________________

Home Phone☐ (____)__________________ Cell Phone☐ (____)_________________Work Phone☐ (____)_______________

(Please indicate the preferred contact number)

Social Security # (if insurance ID #)______________________Birth Date________________ Age_________ Sex M ☐ F ☐

Children's name(s) and age(s)______________________________Email Address_________________________________

(Your email will be added to Chiromedica's database - we will not sell or give away your info)

Favorite hobbies or interests____

Emergency Contact____ Telephone (____)______________________

Physician____Telephone (____)______________________

Who may we thank for your referral?____

Employment Status ☐Full-time ☐Part-time ☐Not working ☐Student

Employer ____Telephone (____)______________________

Injury Type ☐Work ☐Auto ☐Other Injury Date _______________

Attorney Involved ☐No ☐Yes If Yes, then Attorney Name____

Address____ Telephone (____)______________________

INSURANCE PATIENTS ONLY

Primary Insurance____ Telephone (____)______________________

Insured Name ________________________________Subscriber's ID#________________________D.O.B.______________

Secondary Insurance ____ Telephone (____)______________________

Insured Name ________________________________Subscriber's ID#________________________D.O.B.______________

Please note that you are financially responsible for any charges not covered by your insurance plan.

The above is accurate to the best of my knowledge.

Patient Signature ____ **Date** ______________________
(Parent/Guardian, if patient is a minor)

MEDICAL HISTORY

Patient Name ____Birth Date ____________________

Type of Injury / Condition ____Onset / Injury Date __________________

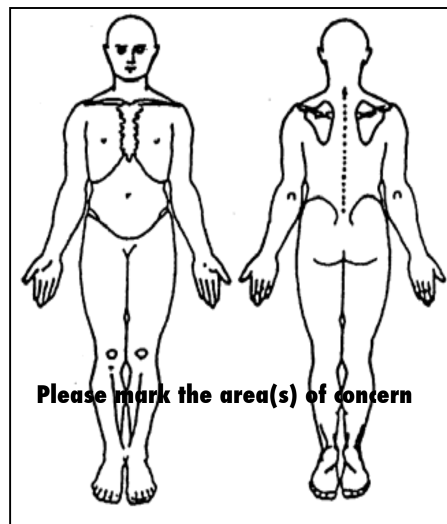
Have you consulted another doctor / practitioner for this health concern? Y / N

If yes, name __________________________________date_____________

Are your health concerns: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you ever been to a chiropractor before? Y / N

If yes, who was the chiropractor? ___________________________________



Have you had any imaging performed:

☐ X-Ray
☐ MRI
☐ Ultrasound
☐ CT Scan
☐ Doppler

Have you recently noted any of the following:

☐ Weight Loss /Gain
☐ Weakness
☐ Pregnant
☐ Pain at Night
☐ Nausea / Vomiting
☐ Fever / Chills / Sweats
☐ Headaches
☐ Cramps in Legs
☐ Fatigue
☐ Numbness / Tingling
☐ Change in Vision/Hearing
☐ Insomnia

Do you have now or have you ever had any of the following:

☐ Neck pain
☐ Headache
☐ Migraines
☐ Tingling/numbness
☐ Arm/hand pain
☐ Mid-back pain
☐ Low back pain
☐ Leg/ankle pain
☐ Knee pain
☐ History of fracture/broken bones
☐ Blood pressure problems/stroke
☐ Paralysis
☐ Depression
☐ Loss of sleep
☐ Painful menstruation
☐ Leg or ankle swelling
☐ Indigestion/heartburn
☐ Loss of consciousness/fainting
☐ Cancer
☐ Motor vehicle accident
☐ Sports injury

Explain & give approximate dates for any items indicated above ____

____

Are you currently taking medications? Yes / No Name or Type of Medication______________________________________

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _________________________________

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? ____

What are your current physical or fitness goals? ____

Is there anything else you would like to include or ask your chiropractor? ____

Patient Signature ____ **Date** ____________________
(Parent/Guardian, if patient is a minor)

OFFICE POLICY

INSURANCE PATIENTS ONLY

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Chiromedica** to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Chiromedica. ____ *(initial)*

FINANCIAL POLICY: If you have provided your insurance information to our office, then we bill your insurance company as a courtesy and will assist you to the best of our abilities with getting your claim paid. However, you are financially responsible for any charges not covered by your insurance plan. In an effort to keep our fees low and your costs manageable, we will collect a co-payment at the time of service. Please note that what we collect in the office may only a *portion* of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement from our billing company. You are ultimately financially responsible for medical services rendered to you.
We have reviewed these benefits with you and you agree to pay your portion of your bill. ____ *(initial)*

SELF PAY PATIENTS ONLY

FINANCIAL POLICY: For patients without insurance, we offer self-pay rates. Payment for self-pay services is due at the time of service. We also offer discounted packages which must be purchased in advance. I understand my responsibility for the payment of my account. ____ *(initial)*

CANCELLATION & NO-SHOW POLICY

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. For the best customer service, we ask that you make schedule changes during our normal business hours.
Appointments cancelled with less than 24-hours notice will be assessed a fee as follows: $25 for chiropractic office visits and $50 for massages. This fee is not covered by insurance and is your responsibility to pay at the time of your next visit.
____ *(initial)*

CONSENT FOR CARE & TREATMENT:

I the undersigned do hereby agree and give my consent for Chiromedica to furnish chiropractic care and treatment considered necessary and proper in evaluating or treating my physical condition. ____ *(initial)*

CONSENT FOR THE TREATMENT OF A MINOR:

As parent and/or legal guardian, I authorize Chiromedica to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature ____**Date** ____________________

Print Patient Name ____

Signature ____ **Date** ____________________
(Parent/Guardian, if patient is a minor)

HIPAA NOTIFICATION

Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Chiromedica is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice on paper.

If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below. If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it.

Acknowledgement
I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ____

Signature: ____

Date Signed: ____

OR

Waiver
I, the undersigned, am aware of my right to receive a paper copy of the above Notice and I have declined such Notice. I am aware that this Notice is available to me from Chiromedica at any time. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ____

Signature: ____

Date Signed: ____