New Patient Health History Form

Welcome to Preston Forest Chiropractic!
In order to provide you the best possible care, please complete this form.
All information is strictly CONFIDENTIAL.

Patient Data: PLEASE PRINT

Legal Name:_____ Nickname:_____

Address:_____ City, State & Zip:_____

Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Marital Status: M S D W Spouse's Name: _____ Spouse's Occupation: _____

Number of Children: _____ # of Children living at home: _____ Height & Weight: _____

Phone: (H) _____-_____-_____ Email Address: _____

Phone: (W) _____-_____-_____ Occupation & Employer: _____

Phone: (C) _____-_____-_____ Referred By: _____

Emergency Contact Information: Name: _____

Relationship to patient: _____ Phone:_____-_____-_____

Current Complaint:

Nature of injury: Auto Work Slip/Fall Other Have you retained an Attorney? Yes No

Please describe:

_____

_____

_____

Date of injury: ____/____/____ Date symptoms first appeared: ____/____/____

Have you had this same condition before? Yes No If Yes, When? _____

Insurance Information:

Name of party responsible for payment _____ Phone: _____-_____-_____

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

If an auto accident, please provide:

Auto insurance company name:_____ Contact person: _____

Claim #:_____ Phone:_____-_____-_____

Signatures:

Name of insured: (please print)_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered and charged to me are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/ treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature: _____ Date: _____/_____/_____

Spouse's or guardian's signature:_____ Date: _____/_____/_____

Care Coordination:

What type of care are you looking for?

_____ Relief _____ Corrective _____ Preventative _____ Doctor's Discretion

Any specific questions you would like the Doctor to answer? _____

_____

_____

Medical History:

Reason for visit: _____

Is this condition getting progressively worse? Yes No

How often do you have pain? Constant Daily Occasionally

Does your pain interfere with:
Work Sleep Daily Routine Leisure

Have you been treated for any condition in the last year? Yes No

If yes, please describe: _____

Date of last physical exam: _____/_____/_____

Is there a chance that you are pregnant? Yes No

Have you had x-rays taken in the last year? Yes No

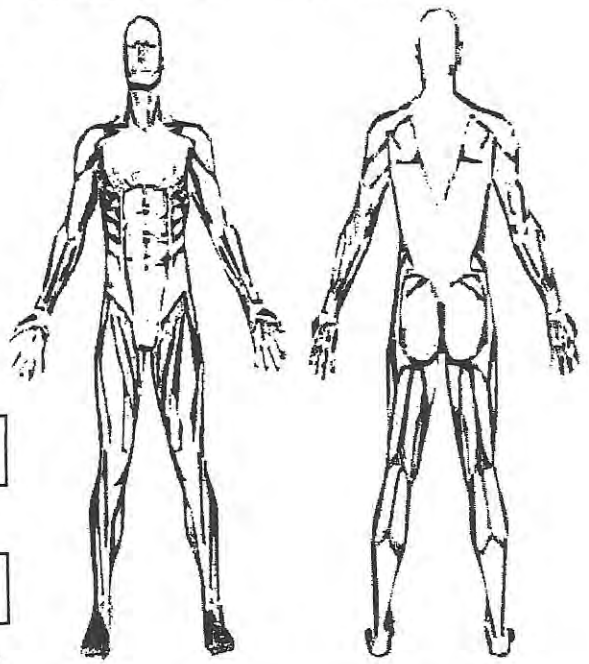
What treatment have you already received for your condition?
Medication Physical Therapy Surgery Chiropractic

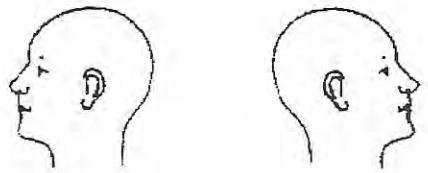
What medications are you taking and for what conditions?
(Please list dosage and amounts, etc.)

What vitamins, minerals or herbs do you currently take?
(Please list dosage and amounts, etc.)

Please use the following letter to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache
B = Burning
N = Numbness
O = Other
P = Pins & Needles
S = Stabbing





Do you experience pain everyday?	Yes	No
Do your symptoms interfere with daily life?	Yes	No
Does pain wake you up at night?	Yes	No
Are your symptoms worse at certain times of the day?	Yes	No
Do changes in weather affect your symptoms?	Yes	No
Do you wear orthotics?	Yes	No
Do you take vitamin supplements?	Yes	No

What activities aggravate your symptoms?

Have you ever:

Briefly Explain:

Broken bones?	Yes	No
Been hospitalized?	Yes	No
Been in an auto accident?	Yes	No
Had Sprain/Strains?	Yes	No
Been struck unconscious?	Yes	No
Had surgery?	Yes	No

Family History:

Family members- Present and past health conditions. (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy	Briefly Explain:
Alcohol					
Appetite					
Artificial Sweeteners					
Coffee					
Drugs					
Exercise					
Salty Foods					
Sleep					
Soft Drinks					
Stress					
Sugary Foods					
Tobacco					
Water					

Have you ever suffered from: (Please check any box that applies)

	Allergies		Kidney Stones
	Anemia		Knee Pain Left Right
	Arm Pain Left Right		Leg Pain Left Right
	Arteriosclerosis		Loss of Balance
	Arthritis		Loss of Memory
	Asthma		Loss of Sleep
	Belching/Gas		Loss of Smell
	Blurred Vision		Loss of Taste
	Bronchitis		Low Back Pain
	Bruise Easily		Low Blood Pressure
	Bursitis		Muscle Twitching
	Cancer		Muscle Weakness
	Chest Pain		Nausea
	Cold/Tingling Extremities		Neck Pain
	Confusion		Nervousness
	Constipation		Nose Bleeds
	Convulsions		Numbness
	Cramps		Pacemaker
	Depression		Pain Between Shoulders
	Diabetes		Pinched Nerve
	Diarrhea		PMS
	Difficulty Breathing		Polio
	Difficulty Chewing		Poor Posture
	Digestion Problems		Prostate Trouble
	Dizziness		Sciatica
	Double Vision		Scoliosis (Spinal Curvature)
	Ear Ringing		Shortness of Breath
	Excessive Menstruation		Shoulder Pain Left Right
	Eye Pain		Sinus Infection
	Fainting		Stomach Pain
	Fatigue		Stress
	Feet/Ankle Pain Left Right		Stroke
	Forgetfulness		Swelling of Ankles
	Frequent Urination		Swollen Joints
	Headache		Tennis Elbow Left Right
	Hemorrhoids		Thyroid Condition
	High Blood Pressure		Tuberculosis
	Hip Pain Left Right		Ulcers
	Hot Flashes		Varicose Veins
	Irregular Heart Beat		Venereal Disease
	Irregular Menstruation		Walking Problems
	Jaw Problem (TMJ)		Wrist Pain (Carpal Tunnel)
	Joint Pain/Stiffness		Other: _____

Office Policy and Insurance Assignment Agreement

This office is pleased to accept your case on assignment as soon as your insurance company and or the responsible party verify your coverage. Verifying insurance is not a guarantee of payment, all information is changeable until the explanation of benefits (EOB) from your insurance company is received. We will file your claim forms to assist you in every way we can for reimbursement.

We must make clear that insurance contracts are between you, the patient, and your insurance company; you are responsible for any amount not paid by your insurance company.

In accepting your insurance on assignment, we are extending you credit. This courtesy may be withdrawn if circumstances warrant.

It is important that you understand the following conditions and agree to them:

1. If you choose to discontinue or dismiss yourself from care without the doctor's authorization **the balance on your account is due and payable in full at the time of your discontinuance even if your insurance has been filed**. If and when your insurance company pays on your account, the remainder will be refunded/ credited once you have a zero balance. **There is a $25 missed appointment charge for all appointment not canceled 24 hours in advance.**

2. Your insurance should pay within 45 days of your office visit. **If your insurance has not paid within 60 days, then you will be responsible to pay the balance due.** You will be reimbursed by your insurance company or by our office when your insurance company pays the outstanding balance.

3. We will continue to bill your insurance on 30-day cycles as long as your are receiving active chiropractic care in our office.

4. You are required to pay $_____ to cover your deductible and _____% and/or $_____ to cover your co-pay and/or co-insurance until the first insurance check or explanation of benefits (EOB) is received. This amount may be changed depending upon what your insurance company's explanation of benefits (EOB) states. Deductibles must be confirmed and satisfied prior to assignment being enacted.

5. Your insurance contract states that your policy has a maximum yearly benefit of $_____ or _____ number if visits. Once you have reached this limit, you will be required to pay for your care out of your own pocket.

6. You are required to sign an "informed consent" and medical records release forms as well as any other assignment documents required by your insurance company.

7. **Our office does not guarantee that your insurance company will pay.** We will make every attempt to obtain verification of policy coverage. However, if for any reason, your insurance claim is denied, you are responsible for the full amount of your balance. Any past due accounts are subject to 20% annually on the aniersary of your last date of service.

8. Our office will, as a courtesy to you and for a limited time, file your insurance and enter into a dispute with your insurance company over any claims not paid or not paid properly but **this is ultimately your responsibility and obligation.**

9. The doctor and patient and/or their representatives in advance of receiving care must sign any special arrangements regarding finances and all agreements will need to be renewed and resigned on the first visit of the new year.

10. If insurance co-pays are not pre-paid then they are due at the time of service. We will attempt to collect any unpaid balance from you but if we are not successful we will send you to collections and report it to all 3 credit bureaus. A $15.00 administrative fee may be assessed if not paid. **Return checks are subject to a $25.00 fee.**

By signing below I state that I have read and agreed with the above statements.

_____ _____

Patient Signature Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____
Printed Name of Patient

_____ _____
Signature of Patient — Date

_____ _____
Signature of Patient's Representative (if minor or physically incapacitated) — Date

_____ _____
Witness to Patient's Signature — Date

_____ _____
Translated By — Date

RECEIPT OF PRIVACY STATEMENT

I understand that as part of my healthcare, Preston Forest Chiropractic (PFC) 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 this information serves as:

- A basis for planning my care and treatment;
- A means of communications among the healthcare professionals who contribute to my care;
- A source for billing and payment by third party payers

I also authorize PFC to release all present and prior medical records to other physicians, specialists or health care providers involved in my health care. PFC has my authorization to release my present and prior medical records to my insurance company or companies to make a complete diagnosis and to process my insurance claim.

I authorize payment of medical benefits to PFC

I understand that I am responsible for reimbursing Preston Forest Chiropractic for financial charges that are not covered by my insurance. If some payment is requested on the date of service, I understand this is only an estimate of the patient responsibility, and that I will be responsible for any additional charges that are not covered by my insurance once the claim has been processed. If I do not have insurance, I understand that I am responsible for all financial charges. I further understand that any payment that is returned (such as a check that is returned due to non-sufficient funds) or has an invalid credit card number, I will be charged an additional fee.

I acknowledge that even though I am agreeing to this paper version of this notice, I understand that I have the right to request a copy of Preston Forest Chiropractic privacy practices.

_____ _____

Patient Signature Date

_____

Patient Printed Signature