

# PATIENT INFORMATION AND HISTORY

Date: \_\_\_\_\_

**1** PATIENT INFORMATION

Name \_\_\_\_\_  
Who referred you here? \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Birth day: \_\_\_\_\_ Age: \_\_\_\_  Male  Female  
Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Parents Name (if a minor): \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
Spouse's Name: \_\_\_\_\_  
# of Children: \_\_\_\_ Name(s) \_\_\_\_\_

**2** INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insurance company \_\_\_\_\_  
Insurance ID number \_\_\_\_\_  
Group / Claim number \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Insurance company \_\_\_\_\_  
Subscriber # and name \_\_\_\_\_  
Subscriber DOB \_\_\_\_\_ Group # \_\_\_\_\_  
Please present insurance card(s) so we can put a copy in your file.

**3** ACCIDENT INFORMATION

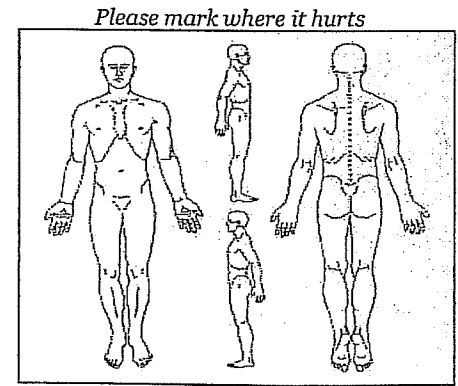
Is your condition due to an accident?  No  Yes Date: \_\_\_\_\_  
Type of accident?  Automobile  Work  Home  Other  
To whom have you reported the accident?  
Insurance  Worker's Comp  Employer  Other \_\_\_\_\_  
Attorney Name (If applicable) \_\_\_\_\_

**4** CONTACT INFORMATION

Home phone \_\_\_\_\_  
Cell phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Email \_\_\_\_\_  
Best way to reach you  Home  Cell  Work  Email  
IN CASE OF EMERGENCY, CONTACT  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

**5** PATIENT CONDITION

What is your major symptom/problem? \_\_\_\_\_  
When did your symptoms begin? \_\_\_\_\_  
Have you had this problem before? \_\_\_\_\_  
Is your condition getting progressively worse? Yes  No   
Is this problem:  constant  comes and goes  
How does it Feel?  Burning  Sharp  Shooting  Dull  Aching  Stiff  
 Tingling  Throbbing  Swelling  Other \_\_\_\_\_  
Circle below the severity of your pain on a scale of 0 to 10:  
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)  
What makes your condition better? \_\_\_\_\_  
What makes your condition worse? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
Activities/movements that are painful to perform:  
 Sitting  Standing  Walking  Bending  Lying down  Driving



# 6

## HEALTH HISTORY

### What other treatments have you had for this condition?

Chiropractic  Orthopedic  Neurologist  Physical Therapy  Medication  Surgery

Name of other doctors who have treated you for this condition \_\_\_\_\_

Describe the other doctor's treatment for your condition \_\_\_\_\_

Previous Chiropractic care?  No  Yes Date \_\_\_\_\_  Local  Out of state \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ MRI \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Dental x-ray \_\_\_\_\_ CT- Scan \_\_\_\_\_

List any Medications you are taking \_\_\_\_\_

Vitamins / Herbs / Minerals \_\_\_\_\_

**Females:** Are you Pregnant  Yes  No Beginning of last menstrual cycle \_\_\_\_\_

### Check any of the following conditions you have had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Ear ringing          | <input type="checkbox"/> Neck pain            |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Poor circulation     |
| <input type="checkbox"/> Arm/shoulder pain  | <input type="checkbox"/> Headaches - Migraine | <input type="checkbox"/> Prostate problems    |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Sciatica             |
| <input type="checkbox"/> Bladder problems   | <input type="checkbox"/> Herniated disk       | <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Sinus infection      |
| <input type="checkbox"/> Chronic fatigue    | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Deafness           | <input type="checkbox"/> Irregular cycle      | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney problems      | <input type="checkbox"/> TMJ                  |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Earache            | <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Vertigo/Dizziness    |

### STRESSORS

Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_  
 Coffee/ Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_  
 High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

### EXERCISE

None  
 Moderate  
 Daily  
 Heavy

### Have you had any:

### Description

### Date

Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

# 7

## AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Northern Life Chiropractic, Heartlight Chiropractic or Finish Line Chiropractic, to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if patient is a minor)

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment we must require you to read and sign this consent form, stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and rights privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.**

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**Name**

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**Date**

# PROFESSIONAL FEE SCHEDULE

## INITIAL VISIT AND STANDARD VISITS

Consultation	No Charge
Examination	\$60 - \$140
X-rays (per view)	\$55
Office Visit, Adjustment	\$55 - \$70
Extremity Adjustment	\$55
Therapies	\$35

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can.

## PLAN 1: GROUP INSURANCE

If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment, do not pay for maintenance care, and ordinarily are designed and intended to only take care of acute problems. Please understand that insurance companies have cost containment programs to reduce the amount of claims paid even when the patient's care is justified.

## PLAN 2: CASH

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

## PLAN 3: HEALTH CARE MADE AFFORDABLE (HCMA)

For those patients who qualify, we offer discounted cash agreements on a monthly and block basis. Please ask for details.

## PLAN 4: WORKER'S COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

## PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

*I have read and understand all of the options available to me.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_