Welcome to CenterPoint Chiropractic
New Patient Paperwork

"Health begins in youth. As a chiropractic physician, it is my hope to enlighten my patients on how chiropractic care will improve their lives and the lives of the generations to come. My goal is to fill the needs of my patients and give them the information necessary to take greater control over their own health care. I am excited about the future of health care and look forward to translating new knowledge into meaningful advances." –Kristina Clay, D.C.

Patient Demographic Information

Name (First)_____ (MI) _____ (Last) _____

What do you prefer to be called? _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ May we leave a message at this number? □ Yes □ No

Work Phone _____ May we leave a message at this number? □ Yes □ No

Cell Phone _____ May we leave a message at this number? □ Yes □ No

Email Address _____ Opt Out of Email □

Gender: □ Female □ Male Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Date of Birth _____ Social Security Number _____

How did you hear about our office or who referred you? _____

Employment Status: □ Employed □ Unemployed □ Retired □ Part-Time Student □ Full-Time Student

Your Employer _____ Occupation _____

Business Address _____ City/State/Zip _____

HIPAA Privacy Requirements

Our practice defines 'personal health information' as any information that is protected under the HIPAA Privacy Rule. It includes, but is not limited to, all appointment information, lab/test results, etc. We will NOT disclose ANY of your personal health information to anyone that is not listed below. Due to the fact that we must have your permission in writing, we will not be able to take verbal verification later. Therefore, please list the names of anyone that you give permission to access your personal health information on the lines below.

Name _____ Relationship_____ Phone Number _____

Name _____ Relationship_____ Phone Number _____

Name _____ Relationship_____ Phone Number _____

Emergency Contact _____ Relationship _____ Phone Number _____

Do you want to allow your emergency contact person access to your personal health information? □ Yes □ No

Primary Care Physician _____ Phone Number _____

May we discuss your medical information with your primary care physician? □ Yes □ No

Responsible Party Information (if other than patient) – Must be completed for all patients under the age of 18

Name of Person Responsible for Payment _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Do you have health insurance? □ Yes □ No Do you have a secondary health insurance? □ Yes □ No

Primary Insurance Information – Only complete if insurance is in anyone's name <u>other</u> than the patient.

□ Same as responsible party

Name of Insured _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Secondary Insurance Information – Only complete if insurance is in anyone's name <u>other</u> than the patient.

□ Same as responsible party

Name of Insured _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Is this visit a result of a Work Comp Injury? □ Yes □ No

Is this visit a result of a Motor Vehicle Accident? □ Yes □ No

Is this visit the result of a Liability Accident? □ Yes □ No

If any of the above three questions were answered YES, please go see the receptionist immediately. Thank you!

CONSENT TO TREAT: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. _____ (patient initials)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of medical benefits furnished to me by the chiropractor(s) of CenterPoint Chiropractic. I understand I am financially responsible for any amount (1) not covered by my insurance company, HMO, POS or PPO and (2) if my insurance company requires a referral and I have not obtained the referral prior to services being rendered. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. _____ (patient initials)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize CenterPoint Chiropractic to release any information acquired in the course of my examination and/or treatment to: (1) my insurance company(ies), (2) to any physician who has referred me for treatment, and (3) to any physician to whom I may subsequently be referred. Also, I give permission to CenterPoint Chiropractic and/or staff to release information (verbal or written) about me, my medical condition and/or treatment to the people listed above under the HIPAA Privacy Requirements section. _____ (patient initials)

CONTACT RELEASE INFORMATION: I agree to permit CenterPoint Chiropractic and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile device concerning any and all aspects of my account: financial, procedural or scheduling. I also give permission to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. _____ (patient initials)

PRIVACY POLICY: I realize that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. _____ (patient initials)

To the best of my ability, the information I have supplied is complete and truthful. I attest that I have read and understand the policies of CenterPoint Chiropractic, and accept my responsibility as stated in those policies. _____ (patient initials)

Patient Signature: _____ **Date** _____

17 years of age and under required signature of Parent/Guardian/Responsible Party

Chief Complaint

Patient Name: _____

Reason for your visit? _____

When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other_____

Pain aggravated by: ☐ Coughing ☐ Sneezing ☐ Straining ☐ Bowel Movement ☐ Neck Flexion ☐ Neck Extension ☐ Neck Rotation ☐ Neck Lat. Flexion

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain from 0 (no pain) to 10 (constant sever pain – incapacitated): _____

Is the pain constant or does it come and go? _____

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

Name and address of other doctor(s) who have treated you for your condition:

_____

Have you had x-rays taken? □ Yes □ No When? _____ Where? _____

Current Review of Symptoms

Dates of last medical exams: _____

Current Medications: _____

Drug Allergies: _____

Other Allergies: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Are you currently trying to become pregnant? ☐ Yes ☐ No Date of last menstrual cycle _____

Please check all symptoms that you are ***currently*** experiencing.

- □ Anxiety
- □ Asthma/Wheezing
- □ Blood in Urine
- □ Blurred Vision
- □ Bronchitis
- □ Change in Voice
- □ Chest Pain
- □ Constipation
- □ Depression
- □ Diarrhea
- □ Dizziness
- □ Edema/Swelling
- □ Fatigue
- □ Fever
- □ Foot/Ankle Swelling
- □ Frequent Urination
- □ Gait Abnormality
- □ Glaucoma
- □ Headache
- □ Hearing loss
- □ Heat/Cold Intolerance
- □ Hormone Replacement
- □ Incontinence
- □ Insomnia
- □ Joint Pains
- □ Kidney Stones
- □ Loss of Appetite
- □ Lumps
- □ Memory Loss/Confusion
- □ Muscle Pain/Cramps
- □ Muscle Weakness
- □ Nausea
- □ Nose Bleeds
- □ Painful Urination
- □ Rash
- □ Ringing in Ears
- □ Shortness of Breath
- □ Sore Throat
- □ Tingling/Numbness
- □ Varicose Veins
- □ Vomiting
- □ Weight Change
- □ Other _____

Daily Habits

Tobacco Use: ☐ Never ☐ Former (Quit Date: _____) ☐ Current (# of Cigarettes/day _____) ☐ Smokeless Tobacco

Water Consumption: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Coffee or Caffeinated Beverage Use: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Alcohol Use: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Recreational Drug Use: ☐ Never ☐ Not Currently ☐ Yes (Please Specify _____)

What type of exercise do you perform on a daily basis? ☐ None ☐ Light ☐ Moderate ☐ Heavy

What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Computer Work

What vitamins do you take? _____

What kind of other nutritional supplements do you take, if any? _____

Patient Name: _____

Are you interested in talking with Dr. Clay about weight loss? □ Yes □ No

Medical Diagnosis

Please check any disease/conditions that you personally have had.

□ AIDS/HIV
□ Alcoholism
□ Allergy Shots
□ Alzheimer's Disease
□ Anemia
□ Anorexia
□ Anxiety
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Breast Lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Depression
□ Diabetes
□ Eczema
□ Emphysema
□ Epilepsy
□ Fractures
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disc
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Influenza
□ Kidney Disease
□ Liver Disease
□ Measles
□ Mental Disorder
□ Migraine Headaches
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Pinched Nerve
□ Pleurisy
□ Pneumonia
□ Polio
□ Prostate Problems
□ Prosthesis
□ Psychiatric Care
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Scarlet Fever
□ Sleep Apnea
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor, Growths
□ Typhoid Fever
□ Ulcers
□ Vaginal Infections
□ Venereal Disease
□ Whooping Cough
□ Other _____
_____
_____
_____
_____

Have you had any broken bones? ☐ Yes ☐ No If yes, please list and give dates _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐ Yes ☐ No If yes, please explain _____

Past Surgical History

Date: Procedure:

_____ _____

_____ _____

_____ _____

Family Medical History

Medical Conditions/Diseases (Diabetes, Cancer, Heart Disease, Back Pain, etc.)

Father _____

Mother _____

Siblings _____

Children _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

Patient Signature: _____ **Date** _____

17 years of age and under required signature of Parent/Guardian/Responsible Party

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing CenterPoint Chiropractic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1. If you do not have health insurance, or your health insurance does not have chiropractic benefits, you are financially responsible for the full amount of services rendered.

2. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the full amount of services rendered.

4. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

5. Before receiving services, you should verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care physician listed on your insurance card before you are seen by another healthcare provider.

6. Co-payments must be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

7. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.

8. Billing and/or finance fees will be added to any patient balance greater than 30 days past due.

9. Personal Injury or Automobile Accidents: It is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case.

By signing below you acknowledge that you have read the Financial Policy and fully understand its terms.

Print Patient Name _____ Date: _____

Patient/Responsible Party Signature _____