MARTIN CHIROPRACTIC

Patient Information

Date: ____ / ____ / ____ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name: Last: _____ First: _____ MI: _____ DOB: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ / _____ / _____ Email: _____

Phone: (____) - _____ - _____ (home) (____) - _____ - _____ (cell) (____) - _____ - _____ (work)

Emergency Contact: Name: _____ Relationship _____ (____) - _____ - _____

How did you hear about our practice? ☐ Internet ☐ Advertisement ☐ Friend, if yes, who**?** _____

Have you had Chiropractic care before? ☐ Yes ☐ No Whom? _____ When: ____ / ____ / ____

Have you seen another doctor for these symptoms? ☐ Yes ☐ No Whom? _____ When: ____ / ____ / ____

Who is your primary care physician? _____ Are you currently under medical care? ☐ Yes ☐ No

List any medications you are currently taking: _____

List any surgeries & hospitalizations: _____

Employment Information **Work status:** ☐ FT ☐ PT ☐ Retired Student: ☐ Yes

Employer: _____ Phone: (____) - _____ - _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Financial Information ~ Health Insurance ***(****please provide us with a copy of your insurance card.)*

Name of Carrier: _____ Policy #:_____ Group #: _____ Telephone #:(____) - _____ - _____

Secondary Ins: _____ Policy #:_____ Group #: _____ Telephone #:(____) - _____ - _____

PERSONAL INJURY PATIENTS ONLY

Accident Information:

Is this visit due to an accident? ☐ Yes ☐ No Date of Accident: ____ / ____ / ____ Was it reported? ☐ Yes ☐ No

Is there an accident report? ☐ Yes ☐ No Name of Insurance company responsible for accident _____

Policy #:_____ Telephone #: (____) - _____ - _____ DL#: _____

Is there an attorney involved? ☐ Yes ☐ No If yes, Whom: _____

Attorney Address#:_____ Telephone #: (____) - _____ - _____ Letter of Protection? ☐ Yes ☐ No

What is your complaint today? ***Where does it hurt?***

☐ Cervical Pain	(**neck**)	☐ Thoracic Pain	(**mid back**)	☐ Leg Pain	(Rt / Lt)	☐ Headache	
☐ Shoulder Pain	(Rt / Lt)	☐ Lumbar Pain	(**low back**)	☐ Knee Pain	(Rt / Lt)	☐ Sacroiliac Pain (**SI**)	
☐ Arm Pain	(Rt / Lt)	☐ Buttock Pain	(Rt / Lt)	☐ Foot Pain	(Rt / Lt)		
☐ Hand Pain	(Rt / Lt)	☐ Hip Pain	(Rt / Lt)	☐ Ankle Pain	(Rt / Lt)	Other: _____	

Have you had these symptoms before? ☐ Yes ☐ No How long?: _____

Date Symptoms began: ____ / ____ / ____. What may have caused this? : _____

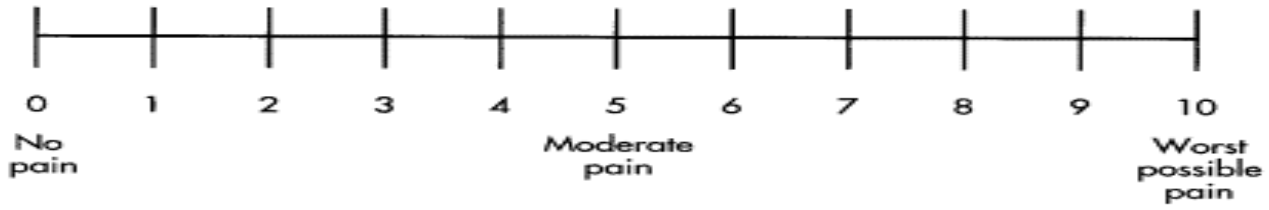
Are these symptoms: ☐ improving ☐ getting worse ☐ same ☐ intermittent (*comes & goes*)

What aggravates your symptoms? _____

What relieves your symptoms? _____

Are you using? **Heat** ☐ Yes ☐ No **Ice** ☐ Yes ☐ No

Pain Scale: *Please rate your pain level below, by circling which applies to you.*



Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea	❑ Blurred Vision
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet	❑ Allergies
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain	
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever	
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting	
❑ Dizziness	❑ Stomach Problems	❑ Shortness of Breath	❑ Bowel/Bladder Changes		

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problem
❑ Anemia	❑ Chicken Pox	❑ Heart Disease	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	
❑ Breast Lump	❑ Goiter	❑ Multiple Sclerosis	❑ Rheumatoid Arthritis	

- *I certify that the above questions were answered correctly.*
- *I understand that providing incorrect information can be dangerous to my health.*

Signature: _____ Date:____ / ____ / ____

Consent To Care

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis.

The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ ___ / ___ / ____

Patient's Signature ***Date***

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, Discover, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____

Patient Signature or Responsible Party *Date*

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and I ***AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE****,* ***Martin Chiropractic, P.A., Inc****.,* ***INSURANCE BENEFITS*** *OTHERWISE PAYABLE TO ME. I understand that I am* ***financially responsible for all charges whether or not paid by insurance****. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.*