WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

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

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) _____ **DATE** _____

INITIAL INTAKE

NAME:_____ DOB:_____ Age:_____ Date of Exam:_____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches
☐ Fibromyalgia
☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the feet
☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Allergies
☐ Digestive Problems
☐ Carpal Tunnel

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
☐ Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)
◆ Medications…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care Dr? _____

Please all medications: (**Be sure to include dosage and frequency**) _____

_____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

Approximate Date of last Flu vaccine:_____ ***WOMEN ONLY:*** Date of LMP:_____ ***Any possibility of pregnancy: YES or NO***

Surgical History:
Surgeries and/or hospitalizations (**type & date**): _____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Social History:

Intake of following: Cigarettes ___ packs/day Alcohol __ ___drinks/week Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Past Medical History and Review of Systems

Y	N	Neurological
___	___	Migraines
___	___	Headaches: how often?_____
___	___	Slurring of speech
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Endocrine
___	___	Diabetes
___	___	Thyroid problems
		Cardiovascular
___	___	High blood pressure
___	___	High cholesterol
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating/Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Medicines previously tried, dosage, duration and outcome.

☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos

Please check ALL options you have previously tried to assist in above symptoms:

____Over the counter medications
____Prescriptions
____Dietary Changes
____Exercise
____ Consult with specialist
____ Supplements
____ Alternative medication/treatment therapies

FINANCIAL POLICY

REGARDING INSURANCE

We may accept assignment of insurance benefits; however, we cannot bill your insurance company without your information and a copy of your card. Your insurance policy is a contract between you and your carrier. We are not a party to that contract. Our office **DOES NOT** guarantee that your insurance will pay. We will make every attempt to receive verification and know what your insurance covers. However, if you claim is denied or paid differently than what your insurance carrier quoted, you are responsible for the bill. Our office **WILL NOT** enter into the dispute with your insurance carrier over your claim. This is your responsibility.

Please be aware that some services may not be covered under your policy, and these will be **YOUR RESPONSIBILITY FOR PAYMENT.**

It is **YOUR** responsibility to inform us of a change in your insurance, name, address, phone number, etc. If your claim is denied because of the updates not being made with out office, the bill is **YOUR** responsibility.

All copays, co-insurance and deductible are due at the time of service, unless other payment arrangements are made prior to the office visit.

If you do not wish to file with your health insurance, we **CANNOT** go back at a later date and file with your insurance. Insurance carriers have a filing time deadline and we are not able to file after you have opted to pay out of pocket. We **CANNOT** go back and file a claim as a workers compensation claim or car accident-**YOU MUST TELL US ON YOUR FIRST DATE OF SERVICE IF IT IS A WORK INJURY OR CAR ACCIDENT!**

CAR ACCIDENTS

If your appointment is due to a CAR ACCIDENT, and you DO NOT wish to file with your PIP (PERSONAL INJURY PROTECTION) We CANNOT go back at a later date and file with the insurance. The insurance company requires certain codes to be used that we DO NOT use with our cash discount.

Patient's or authorized person's signature; I authorized the release of any medical other information necessary to process this claim. I also request payment of benefits be made directly to Chiropractic & Sports Clinic, dba, the phsycian who accepts the assignment.

Printed Name:_____ Signature:_____

Date:

Financial Agreement for Cash Services

The following services performed in our office are considered **CASH SERVICES**. We **DO NOT** file any Medical Health Insurance for payment on these services, nor do we accept any contract rate adjustments from Medical Insurance in regard to these services. We are **UNABLE** to provide claims for these services and the description and/or codes on your receipt can **NOT** be changed.

DECOMPRESSION TABLE/MASSAGE/ LASER THERAPY

Patient Name:_____

Signature:_____

Date:_____

Referral Agreement

Patients whose insurance requires a referral from your primary care physicians are responsible for obtaining that referral. The referral needs to be dated at that time of service to cover all dates of services that are performed for the insurance to cover services.

If a referral is not obtained or claims are denied due to lack of referral, the account balance will become the patient's responsibility.

Chiropractic & Sports Clinic does not take responsibility for denied claims due to lack of referral. We will do the best of our ability to inform you (the patient) if the referral is required by your insurance. However, we cannot guarantee benefits, eligibility and/or referral needs from your insurance.

Patient Name:_____

Signature:_____

Date:_____

Chiropractic & Sports Clinic
821 N Nolan River Rd
Cleburne Tx 76033-7001
(817) 641-4042

Text/Email Consent Form

Consent to Text Message Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information via text from Chiropractic & Sports Clinic.

_____ **(Patient initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(_____)_____

_____ **(Patient initials)** I consent to emails, to receive communications as stated above.

The email address that I authorize to receive messages for appointment reminders, feedback, and general health reminders/information is

_____

_____ **(Patient initials)** I DO NOT consent to receive text messages or emails from the practice at my cell phone or email. I wish to OPT out at this time.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature:

_____ Date:_____

Staff Signature:

_____ Date:_____