Due West Chiropractic and Rehab

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: ___ Gender: F M

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Who should we contact in the event of an emergency? _____ Phone (____) _____

How did you learn about us?

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___

Health insurance Id: _____ Group number: _____

Attorney name: _____ Contact info: _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

Due West Chiropractic and Rehab -- Patient Questionnaire – Non-Accident

Patient Name: _____ Today's Date: ___/___/___

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

☐ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

_____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder
☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite
Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___
2) _____ ___/___/___
3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems
☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder
Other: _____

Due West Chiropractic & Rehab, LLC

Authorizations & Releases/Financial Policy/Lien for Services 2018

SELF-PAY PATIENTS

Consent for Treatment

____ I, the undersigned, hereby authorize the Doctors of Due West Chiropractic & Rehab and whomever they may designate as their assistant(s), to preform evaluations, diagnostic tests, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may occur as a result of this treatment.

Certification, Authorization and Release in Accordance with HIPPA

_____ I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given by me to Due West Chiropractic & Rehab is correct and complete. I understand that my medical information may be shared to manage and expedite my medical treatment. I authorize my treating physician(s) and Due West Chiropractic & Rehab, to secure, release and disclose medical treatment information only with companies, individuals, and any necessary parties involved in my treatment.

Payment Policy

_____ The patient listed below is a self-pay patient. By choosing the self-pay payment option the patient agrees to pay the listed price at each visit based on the services they receive that day and understands that Due West Chiropractic and Rehab will not be billing their insurance for services rendered in our office. The price listed below is a time of service discount.

Treatment for MINORS (UNDER 18)	**$30**
Initial Visit (EXAM & TREATMENT)	**$100**
Chiropractic and Rehab Treatment	**$50**
Decompression	**$50**

Consent for Treatment of Minor

____ I, the undersigned, hereby authorize the doctors of Due West Chiropractic & Rehab and whomever they may designate as their assistant(s), to perform evaluations, diagnostic tests and to administer treatment as is necessary to my child (Child's Name) _____of which I am the legal guardian.

I understand, agree to and will abide by all the above. I will cooperate in processing this claim. I fully understand and acknowledge that I am responsible for all medical charges incurred by me for services provided by Due West Chiropractic & Rehab.

_____	____/____/_____	_____	____/____/_____
Printed Name of Patient	Date of Birth	Signature of Patient	Today's Date