NEW PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT.** **Today's Date** ______________________

Name ____________________________________ **Home Phone** __________________ **Work Phone**______________

Cell Phone _________________ **E-mail Address** ____

Address _________________________________ **City** _____________________ **State** __________ **Zip** __________

Age _______ **Birth Date** __________________ **Marital Status:** S M W D **Number of Children** ______________

Your Employer _____________________________ **Occupation** _________________ **Years On Job** _____________

Employer Address __________________________ **City** _____________________ **State** __________ **Zip** __________

Insurance Company ___________________________________ **Your Social Security #** _______________________

Do you have Medicare? ☐ Yes ☐ No **Do you have Medicaid?** ☐ Yes ☐ No

Name of Spouse or Parent ________________ **Their Phone Number** ____________ **Their Birthdate** _____________

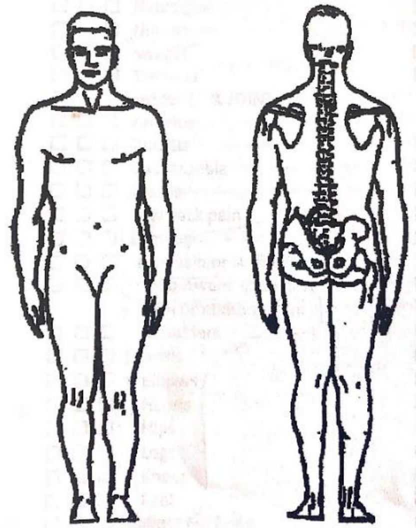
Referred to our office by ____

How payment will be made following today's visit: ☐ Cash ☐ Credit/Debit Card ☐ Check

Please describe your major concerns and mark them on the diagram →

____

____



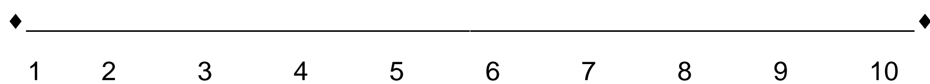
A. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

B. How Often
- ☐ Constantly (Daily)
- ☐ Frequent (Weekly)
- ☐ Occasional (Monthly)
- ☐ Intermittent (Comes and Goes)

C. How long have you been experiencing these symptom(s)
- ☐ Days ☐ Months
- ☐ Weeks ☐ Years

how many _______

D. On the scale below indicate the intensity of your pain at its lowest and highest level.



1 2 3 4 5 6 7 8 9 10

E. Your symptoms are: ☐ Decreasing ☐ Not Changing ☐ Increasing

F. Symptoms are worse in the: ☐ Morning ☐ Night ☐ Increases during the day ☐ Same all day

Is your condition due to an accident? ☐ Yes ☐ No **Date of the accident?** ______________________________

Type of accident? ☐ Auto ☐ Work/On Job ☐ At Home ☐ Other ___________________________________

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Never

Notice to our new patients: *Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.*

Patient or Guardian Signature ____ Date _________________

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if Upper Cervical Care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name____ Date______________________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Burning/tingling
- ☐ Numbness
- ☐ Tremors
- ☐ Anxiety
- ☐ Depression

MUSCLE & JOINT

- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders

PAIN OR NUMBNESS IN:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Sciatica

GASTRO-INTESTINAL

- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen

EYES, EARS, NOSE & THROAT

- ☐ Asthma

CARDIO-VASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Rapid heart beat
- ☐ Slow heart beat

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Frequent urination

FOR WOMEN ONLY

- ☐ Excessive menstrual flow
- ☐ Irregular cycles
- ☐ Painful menstruation
- ☐ Are you pregnant?
  ☐ yes ☐ no

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Adrenal Fatigue
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough

What is your main goal in seeking care at our clinic?

____

____

____

What makes your condition(s) better?

☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other_____________

CONFIDENTIAL PATIENT CASE HISTORY

What makes your condition(s) worse?

☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other____________

Have you seen another health care provider for this condition(s)?

☐ No ☐ Yes Type of provider(s) seen ________________________________

Diagnosis and treatment received to date for this condition(s)? ________________________________

List surgical operation(s) and year(s): ________________________________

____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle relaxers ☐ Birth control pills

Others: ____

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: ____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ____________________

HAVE YOU EVER:	**Yes**	**No**	**DESCRIBE BRIEFLY**
Been knocked unconscious?	☐	☐	____________________
Used a cane, crutch, or other support?	☐	☐	____________________
Been treated for a spine/nerve disorder?	☐	☐	____________________
Had a fractured bone?	☐	☐	____________________
Been hospitalized for anything other than surgery?	☐	☐	____________________
Do you:			
Now take vitamins or minerals?	☐	☐	____________________
Think you may need vitamins or minerals?	☐	☐	____________________
Have an allergy to any drug?	☐	☐	____________________

Habits	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (name of relative or close friend not living in your home:

NAME: ____

ADDRESS: ____ PHONE: ____________________

OFFICE FINANCIAL POLICY

DEAR PATIENTS:

We welcome you and your family to our office. We take pride in providing quality Upper Cervical Care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY:

- Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records.
- Our doctor is not in any insurance networks. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to find out what they will cover.
- Payment is due the day service is provided. If you have insurance, we will gladly file it for you so that you may receive any reimbursements per your policy.
- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services.
- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.
- In accordance with Medicare Law, our office ***cannot*** give any special promotions or offers to patients who receive Medicare benefits.
- By law, a fee of up to, but not to exceed 40% may be added to any account that is turned over to our collection agency.

CANCELLATION POLICY:

If for any reason you cannot make your pre-scheduled appointment time, we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment more than three times an administrative fee of $25.00 will be charged to your account. No further treatments will be administered until this fee is paid.

We are at a point in our clinic where we are extremely busy and need every available time slot for patients who NEED care.

If you consistently miss your pre-scheduled appointments, we can and will **dismiss** you from our practice. We will give you the names of other Doctors within town to better suit you needs. We thank you for your understanding.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_______________________________________ _______________________

Patient's Signature Date