Salisbury Chiropractic, PC

Patient Data **Date** ____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth ___/___/_____ **Age:**_____ **Sex:** □ Male □ Female **Height:**_____ **Weight:**_____

SSN _____-____-_____ **Marital Status:** □ Single □ Married Divorced Widow

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Spouse Data ____

First Name _____ **Middle Initial** _____ **Last Name** _____**DOB:**_____

Home Phone (_____) _____-_____**Work Phone (_____)** _____-_____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Doctor's Signature _____

Patient Name____**Date**_________________

How did you hear about our office? ____

Surgeries: (Circle all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other ______________	Medical Device Implants eg: Pacemaker, etc.	NONE Apply	

Allergies: (Circle all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _________

☐ Medication Allergies:______________________________ NONE

Social History: (Circle all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐never
Drink Alcohol: ☐	occasional	☐ often	☐never
Cigarettes:	<1 pack/day	>1 pack/day	never
Exercise:	☐ occasional	☐ often	☐ never

Family History: (Circle all that apply)

Rheumatoid Arthritis:	☐Mother	Father	☐ Sibling	Grandparents
Asthma	Mother	Father	☐ Sibling	Grandparents
Cancer:	Mother	Father	☐ Sibling	Grandparents
Diabetes: ☐	Mother	Father	☐ Sibling	Grandparents
Heart Disease	Mother	Father	☐ Sibling	Grandparents
Hypertension	Mother	Father	☐ Sibling	Grandparents
Stroke	Mother	Father	☐ Sibling	Grandparents
Multiple Sclerosis	Mother	Father	☐ Sibling	Grandparents

Occupational Activities: (Circle one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper

☐ Other ________________

Doctor's Signature ____

Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression				Tinnitus			
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness/Tingling								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Sweating				Joints Replaced			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Cancer				Broken Bones			
Weight Loss/Gain				Type				Arthritis			
Low Energy Level								Type			
Difficulty Sleeping											

Please list all current medications being taken (including over-the-counter)

_____

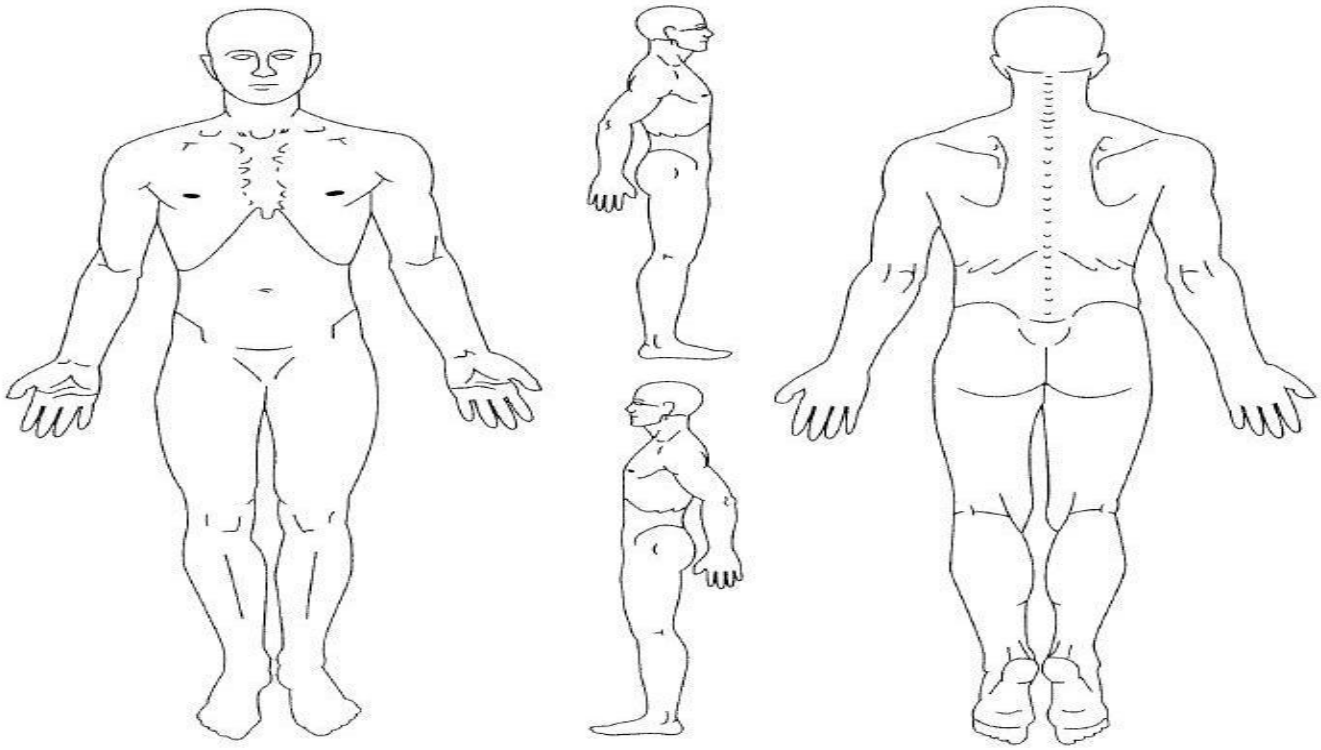
_____

Doctor's Signature _____

Patient Name_____ Date_____

Are you pregnant? Yes_____ No _____N/A_____

Indicate area(s) of pain with "X" and rate your pain levels on a 0-10 pain scale with 10 being worse pain imaginable.



Describe your pain areas _____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: □ Motor Vehicle Collision □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Occasionally (26-50% of the day)	□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Dull ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Stabbing	□ Stiff

How are your symptoms changing?

□ Getting better	□ Not changing	□ Getting worse

Doctor's Signature _____

Patient Name_____ Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Provide the following information if you are NOT the primary policy holder:

Policy Holder's Name: _____

Policy Holder's Date of Birth _____ / _____ / _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date_____

SIGNATURE OF PHYSICIAN: _____ Date: _____

Salisbury Chiropractic, PC
Financial Policies

The goal of Salisbury Chiropractic, PC is to do all that is possible to help receive the highest degree of chiropractic care available. There is a financial aspect to your healthcare as well, and we have prepared these policies to keep you aware of your current insurance benefits and payment policies.

1. The insurance you have is an agreement between you and the insurance company. Waiting for insurance is a courtesy and may be withdrawn at any time.

2. We will gladly file your insurance for you at no charge to you. The insurance is filed every week.

3. Proof of your deductible being met is required; otherwise, full payment for services rendered is expected until the deductible is met. If there is an over-payment we will gladly refund it to you.

4. You will be responsible to pay your co-pays and also any co-insurance portion that your insurance company does not pay.

5. Our insurance department will contact either your insurance carrier or your employer to obtain the proper information concerning deductibles, co-pays and co-insurance, limitations, exemptions, etc.

6. Each insurance policy is different and that is how we are choosing to treat it.
This office DOES NOT promise that an insurance company will pay. Nor does the office promise that an insurance company will or should pay the fees billed.

7. Once a claim is filed and we receive payment, we will check each detail to make sure that it is paid correctly and we will contact the carrier for an explanation as to how the claim was paid if necessary. Sometimes we may ask for your help if that information cannot be shared with us by your insurance company. This office will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. THIS IS A PATIENT OBLIGATION

8. Please be advised that if your insurance company chooses not to pay for a certain procedure, it will be your responsibility to do so. We will bill you and expect prompt payment from you.

9. Balances over 60 days past due will be charged a $2.00 monthly service fee for billing. There will also be a fee for having to send a certified letter to you as well as an 18% fee if your account goes into collection.

10. If your check is returned for any reason we will charge any fees we incur from the bank.

11. If you are being treated for injuries in an auto accident or work related accident, please keep in mind that you are ultimately responsible for making sure that your bills are paid in full.

We're here to help you in any way we can. Please feel free to talk to us about any particular situation that may arise with any of our procedures, policies, or insurance.

I have read and understand this office's financial policies.

_____ _____

Signature Date