

WELCOME

1

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2

INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

3

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

4

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK

5

REASON FOR VISIT

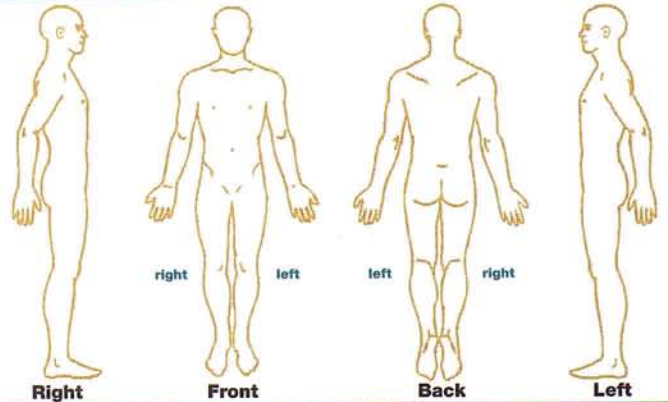
Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness
 Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
 Did your injury occur during: Work Sports/play Auto Accident Routine/Household activity
 When did your condition/accident occur? ___ / ___ / ___ Where did your injury occur? _____
 Please explain what happened: _____
 Is your condition getting worse? Yes No Constant Comes and goes.
 Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?
 Yes No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? Yes No If so, where? _____

Have you ever been treated by a Chiropractor? Yes No
 Clinic or Dr's name: _____
 Clinic phone#: _____



6

HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain killers(including aspirin) Muscle relaxers

Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|--------------------------------------|---------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV+ / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe / Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers / Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes ___ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ___ / ___ / ___

For women: Are you taking Birth Control? Yes No

Are you Nursing? Yes No Are you Pregnant? No Yes If so, how many weeks? _____

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___ / ___ / ___

Adult Patient Parent or Guardian Spouse

**UPDATE
(OFFICE USE)**

Initials _____ Date ___ / ___ / ___

Comments _____

Initials _____ Date ___ / ___ / ___

Comments _____

Initials _____ Date ___ / ___ / ___

Comments _____

PLEASE RECOVER TO WHAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Our Financial Policy

We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please do not hesitate to ask if you have any questions about our fees, Financial Policy or your responsibility.

All Patients must complete our confidential Patient Information Form before seeing the Doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICES RENDERED. Should the patient terminate care without valid reason, any fees for professional services become the full responsibility of the patient and will become immediately due and payable, unless other arrangements are made.

ADULT PATIENTS are responsible for full payment at time of service.

MINOR ACCOMPANIED BY AN ADULT. The Adult accompanying a minor or his/her parents (or guardians), are responsible for full payment at the time of service.

REGARDING INSURANCE

Insurance is a contract between you and your Insurance Company. We are NOT a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account. Should the patient terminate care and treatment, any fees for professional services will become immediately due and payable.

MEDICARE BENEFITS

Medicare does cover Chiropractic care, but with limitations. Medicare requires that you have current x-rays of your spine and x-rays must show subluxation. Medicare does not cover the cost of the x-rays although Medicare does require them. Also not covered are any therapies, supports, supplements, examinations, or other services offered in this office. The only service covered by Medicare is manual manipulation of the spine. Under some circumstances and with some Medicare carriers, these manipulations are limited to twelve (12) per year. Your condition may require, in our judgment, more treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will then be sent for review. We cannot guarantee or predict what the review board will decide in your case. Any visits over twelve (12) will be your financial responsibility.

I hereby authorize **White Marsh Spine and Health Center** to release any information to my insurance company or attorney acquired in the course of my examinations or treatment. I understand that a photo copy of the above assignment and authorization will be deemed as valid as the original.

Should the account become delinquent, the patient agrees to be responsible for all cost of collection including, but not limited to court cost and an attorney fee of 25 % of the balance.

I have read and understand the above statements.

Signature: _____ Date: ____/____/____