Marcon Chiropractic & Wellness Center

New Patient Appointment

You are receiving this email from Marcon Chiropractic & Wellness Center because you have recently scheduled a New Patient Appointment. We have allocated an hour for your Consultation, Comprehensive Examination and Treatment. Please read the information provided below to make sure we have everything we need to get you started right away.

- We have attached your New Patient Paperwork. Please fill it out ahead of time to maximize your appointment time with the Doctor. You need not fill in information on insurance. We will get that information from your card upon arrival.
- You will need your Insurance Card, or, in the case of Workers' Comp and Personal Injury Cases, paperwork verifying your Claim Number.
- If you wish Insurance Verification prior to your appointment, contact our office and we will accommodate your request.
- In addition to your Insurance information, you will need to bring a photo ID.
- Patients under the age of 18 must be accompanied by a Parent or Guardian. Patients over 16 years of age may come alone to follow-up appointments.
- Please bring disks or reports of recent x-rays or special imaging on your first appointment.
- If you are unable to make your appointment, we would appreciate at least 24-hour notice. We understand in rare cases this may not be possible, but prompt action allows us to schedule other patients.
- If you fail to arrive or do not cancel your Initial Appointment within 24 hours of your scheduled appointment time, you will be required to pay a $100 cancellation fee before you will be allowed to reschedule another appointment.
- If you were referred to our office, we would love to know by whom so we can show our appreciation.

If you have any question prior to your appointment, feel free to call our office at (513) 474-1111 or email us at contact@marconchiropractic.com

We look forward to meeting you in person and helping you Move and Feel Better.

Sincerely,

Kathy D'Agostino
Office Manager

463 Ohio Pike; Suite 104 Cincinnati Ohio 45255

(513) 474-1111

Contact@marconchiropractic.com

MARCON CHIROPRACTIC & WELLNESS CENTER

David J. Marcon, DC, CCSP

463 Ohio Pike, Suite 104 Cincinnati Ohio 45255

Please Print

Date: _____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Cell Phone Carrier: VZW, SPRINT, METRO, ATT, TMOBILE, BOOST, CINGULAR, USCELL, VIRGIN

Patient Name: _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address:_____(P/B) Sex: F or M Age: _____ Date of Birth: _____

Circle One: Single / Divorced / Widowed / Minor / Married / Separated / Partnered

Patient Employer/School: _____ Occupation: _____

Employer/ School Address: _____ Employer/ School Phone: (_____) _____

In case of Emergency, who should be notified? _____ Phone: (_____) _____

Were you referred to our Office? Y / N If so, by whom? _____

Full Name of Primary Insured: _____ Relationship: _____

If Other then Patient: Date of Birth: _____ Social Security Number: _____

Employer: _____ Name of Insurance Company: _____

Subscriber ID: _____Group #:_____

Secondary Insurance

Full Name of Primary Insured: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Name of Insurance Company: _____ Subscriber ID:_____

I certify that I, and/or my dependent(s) have insurance coverage with _____ and authorize payment to Clough Chiropractic, Inc. DBA Marcon Chiropractic & Wellness Center, all benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether paid by insurance, and for all services rendered on my behalf or my dependents. The above named corporation may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. I authorize the use of my signature on all Insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

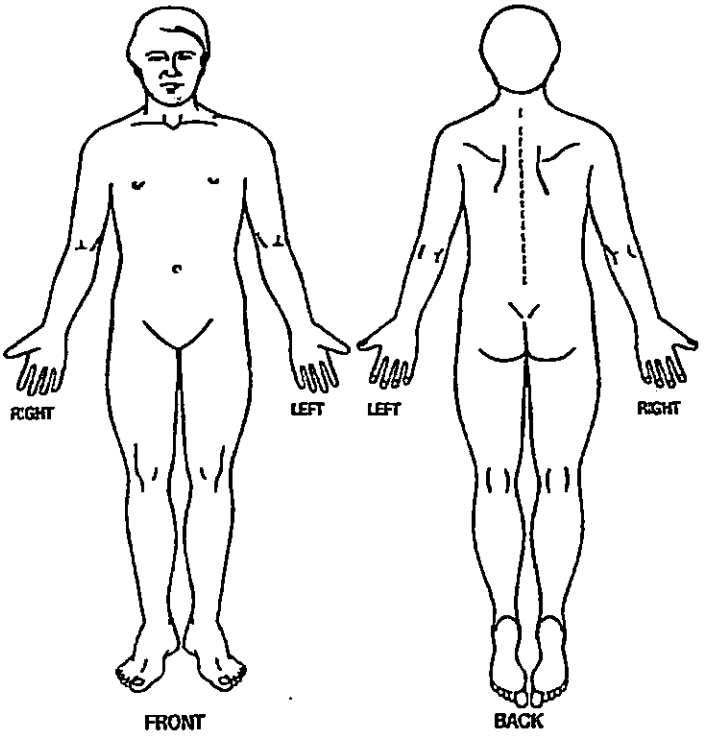
Signature of Patient, Guardian or Person Responsible Date

_____ _____

Please print name of Patient, Guardian or Person Responsible Relationship to Patient

Patient Name: _____ Date: _____

Please Place an X over the area(s) where you experience pain or discomfort



Please check any of the following that apply to you:

	Recent Weight Gain/Loss		Upper Back Pain		Metal Implant(s)
	Weakness		Lower Back Pain		Headaches
	Fatigue		Hip Pain		Loss of Consciousness
	Fever		Leg Pain		Dizziness
	Fainting Spells		Ankle/Foot Pain		Memory Loss
	Nausea		Numbness Legs or Feet		Seizures/Convulsions
	Vomiting		Joint Swelling		Double Vision
	Balance Problems		Tension		Blurred Vision
	Jaw Pain/TMJ		Nervousness		Loss of Vision
	Neck Pain		Anxiety		Light Sensitive
	Neck Stiffness		Irritability		Loss of Hearing
	Shoulder Pain		Problem Sleeping		Ringing in Ear/Tinnitus
	Arm Pain		Depression		Ear Infections
	Wrist/Hand Pain		Liver Problems		Vertigo
	Numbness Arms or Hands		Cancer ⇩		Discharge from Ears

_____

Where & What Type?

Patient Name: _____

Please check any of the following that apply to you:

	Nose		Mouth/Throat		Respiratory
	Sinus Problems		Tooth Pain		Difficulty Breathing
	Nose Bleeds		Lesions-Sores Gums/Lips		Chronic Cough
	Loss of Smell		Difficulty Swallowing		Asthma/ Bronchitis
	Discharge from Nose		Frequent Sore Throats		Emphysema
	Cardiovascular		**Gastrointestinal**		**Endocrine/Hormonal**
	Chest Pain		Up Set Stomach		Diabetes Insulin: Y / N
	Shortness of Breath		Loss of Appetite		Cold or Hot Spells
	Palpitations		Heart Burn/GERD		Excessive Sweating
	Night Sweats		Constipation		Excessive Thirst
	Cold Feet and/or Hands		Diarrhea/Loss Stools		Thyroid Problems
	High Blood Pressure		Blood in Stools		Kidney Problems
	Low Blood Pressure		Abdominal Pain		
	Heart Murmur		Excessive Gas/Bloating		
	Ever Have an EKG		Loss of Bowel Control		
			Genital Urinary (Female)		
	History of Pelvic Inflammatory Disease		Urinary Tract Infections		Breast Cancer
	Currently Pregnant		Blood in Urine		Loss of Bladder Control
	Menopause- Age: _____		Last OB-GYN Appt: _____		
			Genital Urinary (Male)		
	Prostate Problems		Hernia		Blood in Urine

Medication	Reason for Use	Prescribing Physician

X_____ ___/___/_____

Patient Signature Today's Date

MARCON
CHIROPRACTIC
& WELLNESS CENTER

All healthy relationships are built on mutual trust and respect. I, as the Doctor, will make every effort to stay on schedule and give you the time and attention you need. In return I ask that you the patient to:

1. Arrive on time for scheduled appointments.
2. Dress appropriate for Treatment. The area of chief complaint should be easily accessible. ***We do have disposable shorts for special circumstances.***
3. Call us when you are running late or unable to keep the appointment.
4. If you are unable to make a scheduled appointment we ask that you notify the office no later than 12 hours in advance of the appointment. Each patient is afforded the courtesy of a single missed/non-canceled appointment-Everyone forgets occasionally. If you miss a second scheduled appointment without proper notification, you will **not** be assessed a fee but we will not reschedule you for treatment until you meet with someone from our office to explain your circumstances. If we all are in agreement that you will be able to manage appointments moving forward we can resume scheduling.

No amount of "Missed Appointment" fees can recoup time and despite the power of Chiropractic Care, it doesn't work if you don't show up.

5. If you have a complaint or concerns TELL US. If you like the way you feel TELL OTHERS. Both are indispensable to our success.

David J. Marcon, DC

"Doc"

_____

Patient Name/Date

Chiropractic Consent Form

HIPAA

The undersigned gives Clough Chiropractic, Inc. DBA: Marcon Chiropractic & Wellness Center permission to submit claims and any relevant documentation to the patient's Insurance Provider for the purposes of reimbursement.

Clough Chiropractic, Inc. will not release information to any other 3rd Party without written permission of the Patient.

X-RAY RELEASE AND CONSENT

By signing below the Patient gives Clough Chiropractic, Inc. permission to access medical documents from other Medical Providers, including radiology reports and office notes.

X_____

Printed Name of Patient

X_____

Signature of Patient Date

X_____

Signature of Representative (if patient is a minor or has disability)

_____

Date

Marcon Chiropractic & Wellness Center

463 Ohio Pike; Suite 104 Cincinnati, Ohio 45255

(513) 474-1111 contact@marconchiropractic.com

Patient Name: _____ Date: _____

Shoe Orthotics

Have you ever worn shoe orthotics? Yes or No

If yes, please answer the following:

- Are you currently wearing the orthotics? Yes or No
- How long have you been wearing the orthotics? _____
- Were your orthotics prescribed by a physician? Yes or No
- If your orthotics were prescribed, who was the physician and what is the name of their practice?

  _____

- Were your orthotics fitted to your feet? Yes or No
- What is your primary reason for wearing the orthotics?

  _____