MIDTOWN
CLINIC OF CHIROPRACTIC

PERSONAL INFORMATION / APPLICATION FOR CARE

Today's Date:_____

Last Name: _____ First Name:_____

Social Security #:_____

Number of Children:_____Ages:_____

Emergency Contact:_____ Phone Number:_____

Relationship to Emergency Contact:_____

Name of Spouse or Parent:_____ Date of Birth:_____

Occupation: _____ Time at Job:_____

Job Descriptions (Standing? Sitting? Heavy Lifting? Computer Work?)_____

_____

Have you ever been in an auto accident or other type of accident? Yes_____ No_____

Past Year_____ Past 5 Years_____ Over 5 Years_____

Describe accident/ Traumas:_____

_____

Are you on any medication right now? Yes____ No____ List medications:_____

_____

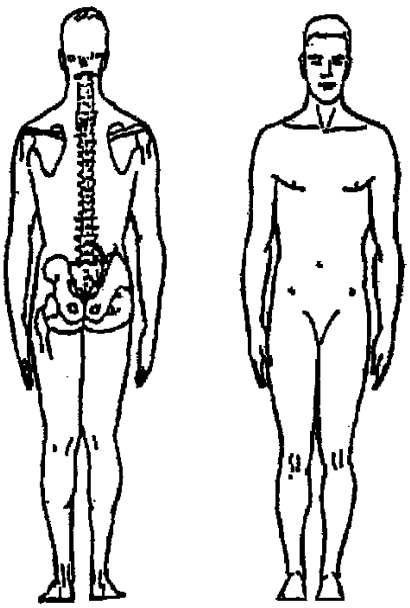
Any side effects from medication:_____

Do you have any allergies? _____

Have you had any surgeries? (Include dates)_____

Any residual effects from surgery?_____

_____



<u>Complaints, conditions or current problems</u>

(Please list any and all conditions you are experiencing)

_____

_____

_____

_____

_____

_____

_____

Rate pain 0 1 2 3 4 5 6 7 8 9 10 (10 being worst pain ever experienced)

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
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness/depression
- ☐ Neuralgia
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors

MUSCLE & JOINT

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Hernia
- ☐ Low back pain
- ☐ Lumbago
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders

Pain or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Painful tail bone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen joints

GASTRO-INTESTINAL

- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT

- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental Decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

CARDIO-VASCULAR

- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

RESPIRATORY

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐Varicose veins

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

FOR WOMEN ONLY

- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes

- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Yes ☐ No Are you pregnant?

Informed Consent for Chiropractic Care:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/ or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position. If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider. Chiropractic care has been proven to be very safe and effective. It is not usual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, or dizziness.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Release of Medical Records:

I give my permission for Dr. Colon to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current information.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of_____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____

Print Name Signature Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual cycle:_____

_____ _____ _____

Print Name Signature Date

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

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

_____ _____

Patient's Signature Date