PATIENT INFORMATION

Full Legal Name: ____ **Preferred First Name:** _______________

Social Security # (used for insurance purposes only)**:** _____________________________________

Address____ **Phone #**_____________________________

City____ **State**________ **Zip**___________________

Sex: M____ F____ **Age**_________ **Birthdate**_________-_________-_________ Married: ______________

Patient Employed by__________________________________ Occupation___________________________

Family Medical Doctor_____________________ In case of emergency notify___________________ Phone________________

Whom may we thank for referring you? _____________________________

** **Email**: ____
(Used for Patient Appointment Reminders)

Primary Area of Problem or Reason for Visit: ____

____

____

____

____

PRIMARY INSURANCE

Insurance Company_______________________________________ Phone_______________________

ID #____ **Group #**___________________________________

Full Name of Person Responsible for Account____

Relationship to Patient________________ Birthdate_______-_______-_______ Soc. Sec._________________________

Street Address ______________________________ Phone_________________________

City__________________________________ State_____________ Zip__________________

ADDITIONAL INSURANCE

Additional insurance? Yes _______ No ________

Insurance Company_______________________________________ **Phone #**_________________________

I.D.____ **Group #**___________________________________

Subscriber Name__________________________________ Relationship to patient______________Birthdate______-______-______

AGREEMENT & RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with:

(Name of insurance co.) ____

I assign directly to Cook Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether paid by insurance or not.

I hereby, authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

*X*____________________________________ _______________________ _________________

Responsible Party Signature **Relationship** **Date**

NAME:

Please mark whether you have these symptoms by writing a "C" for currently or a "P" for in the past, and when applicable please write RIGHT or LEFT side. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT

NEUROLOGICAL

_____ SEIZURES / CONVULSIONS
_____ DIZZINESS / FAINTING
_____ HEADACHE(S)
_____ NUMBNESS / TINGLING
_____ CARPAL TUNNEL
_____CONCUSSION

MUSCLE & JOINT

_____ NECK
_____ UPPER / MID BACK
_____ SHOULDER(S)
_____ ARM(S)
_____ ELBOW(S)
_____ WRIST(S)
_____ HAND(S)
_____ LOW BACK
_____ HIP(S)
_____ LEG(S)
_____ KNEE(S)
_____ FOOT
_____ ARTHRITIS
_____ BURSITIS
_____ FIBROMYALGIA
_____ ARTIFICIAL JOINT

GASTRO-INTESTINAL

_____ COLON TROUBLE
_____ CONSTIPATION
_____ DIARRHEA
_____ DIFFICULT DIGESTION
_____ DISTENSION OF ABDOMEN
_____ GALL BLADDER TROUBLE
_____ HEMORRHOIDS
_____ LIVER TROUBLE
_____ STOMACH PAIN / CRAMPS

EYES, EARS, NOSE & THROAT

_____ LOSS OF HEARING
_____ EARACHE
_____ RINGING IN EAR(S)
_____ VISION ISSUES
_____ SINUS INFECTION

CARDIOVASCULAR

_____ HARDENING OF ARTERIES
_____ HIGH / LOW BLOOD PRESSURE (circle one)
_____ PAIN OVER HEART
_____ POOR CIRCULATION
_____ RAPID/ SLOW HEART BEAT
_____ PACEMAKER / DEFIBRILLATOR
_____ SWELLING OF ANKLES

RESPIRATORY

_____ CHEST PAIN
_____ CHRONIC COUGH
_____ DIFFICULTY BREATHING / ASTHMA
_____ SPITTING UP BLOOD / PHLEGM

GENITO-URINARY

_____ BED-WETTING
_____ BLOOD IN URINE
_____ KIDNEY INFECTION / STONES
_____ PAINFUL URINATION
_____ PROSTATE TROUBLE

FOR WOMEN ONLY

_____ NUMBER OF CHILDREN
_____ AGES OF CHILDREN
_____ BREAST PAIN / CONGESTED
_____ CRAMPS OR BACKACHE
_____ IRREGULAR / PAINFUL CYCLE
_____ MENOPAUSAL SYMPTOMS
PREGNANT? (CIRCLE) YES or NO
DATE OF LAST PERIOD ___________
PAST MISCARRIAGE(S)? YES / NO (circle)

CHECK IF YOU HAVE THESE HABITS
CIRCLE IF YOU HAD THESE HABITS

____COFFEE
____DRUGS
____TOBACCO
____ALCOHOL

CHECK IF YOU HAVE EVER HAD or BEEN:

____CHIROPRACTIC TREATMENT
____ORTHOPEDIC / NEUROLOGIST CARE
____PAIN CLINIC
____PHYSCIAL THERAPY
____CORTISONE /TP / EPIDURAL INJECTIONS
____A FRACTURED BONE

DATE OF LAST: (APPROX.)

_______ PHYSICAL EXAMINATION
_______ SPINAL X-RAY / CT / MRI

***CHECK* THE FOLLOWING CONDITIONS *YOU HAVE OR HAVE HAD*.**
CIRCLE THE ITEMS THAT ARE COMMON TO *OTHER FAMILY MEMBERS*

____DIABETES	____EMPHYSEMA	____DEMENTIA / ALZHEIMER'S
____CANCER	____APPENDICITUS	____PARKINSON'S
____STROKE	____ARTHRITIS	____MULT. SCLEROSIS
____HEPATITIS	____ULCERS	____ALCOHOLISM
____HEART DZ	____PSYCHOLOGICAL DISORDERS / DEPRESSION	

PLEASE LIST ALL MEDICATIONS, VITAMINS & SUPPLEMENTS YOU ARE CURRENTLY TAKING:

____
____
____

AFTER READING & FILLING OUT THE HEALTH QUESTIONNAIRE, YOUR SIGNATURE WILL VERIFY THAT ALL OF THE INFORMATION YOU HAVE GIVEN US IS ACCURATE & THAT YOU HAVE UNDERSTOOD & READ THE CASE HISTORY QUESTIONS CAREFULLY. THANK YOU.

PATIENT SIGNATURE: *X*____________________________________ DATE: __________

INFORMED CONSENT TO CHIROPRACTIC CARE

Patient: Please discuss any questions or concerns you may have, in regards to this consent, with the doctor before signing this informed consent. *I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by this office.*

Patient Signature: *X*__________________________________ Date:______________

Parent/Guardian Signature: *X*__________________________
(If patient is a minor)

PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. *I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure.* **At the present time,**

_____ I am sure that I am not pregnant _____ I could be pregnant _____ I am pregnant

Patient Signature: X _____________________________ Date:________

Parent / Guardian Signature: X__________________________
(If patient is a minor)

ASSIGNMENT OF BENEFITS for Cook Chiropractic & Rehabilitation

In consideration of your undertaking to render care, I agree to the following: ***Release of Information***

1.) You are authorized to release any information you deem appropriate concerning my physical condition, any insurance company, attorney of adjuster in order to process any claim for reimbursement of charges by me at your treatment facility
2.) I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name which you are legally entitled.
3.) In the event any insurance company or attorney, obligated by contractual agreement to make payments, me for your service charges, refuses to make such payment upon demand by you, I hereby assign you to prosecute said action either in my name or you name as you otherwise resolve said claim as you see fit, I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part what is due) shall be paid by me.
4.) I also assign to you, the medical provider, and grant the right to lien against many and all claims again any third party whose negligence may have caused my injury, including their insurance, up to the amount of bill for treatment.
5.) I waive the Statue if Limitations regarding my doctor's rights to recover from me directly.

Patient Signature: *X*__________________________________ Date:______________

Parent/Guardian Signature (if patient is a minor): *X*______________________

FINANCIAL POLICY

As a courtesy to our patients, we offer the following billing options. Please **initial** the one that applies to you and **sign** at the bottom of the page.

PRIVATE PAY

______ I will pay for all services, as they are rendered, and submit my own insurance claims.

GROUP / HEALTH / PERSONAL HEALTH INSURANCE

_____ I would like to assign my benefits to your office and have you submit my insurance claims for me. I understand that I am responsible for whatever co-payment, deductible, and non-covered services that my plan has set forth. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan. I understand that if my insurance company does not pay the balance within 45 days of submission, I am responsible for the entire balance overdue.

AUTO ACCIDENT / PERSONAL INJURY

_____ I was involved in an automobile accident/personal injury and would to like to assign benefits to your office and have you submit all charges to insurance company for me. I will sign all liens necessary to protect your office. I also understand that regardless of settlement, I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid within 45 days of claim submission, I will personally pay the entire overdue balance.

WORKER'S COMPENSATION

______ I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e., accident report, etc.). I understand that it is my right as a Pennsylvania citizen to have any bills incurred as a result of a work-related accident paid for. I will read the Pennsylvania worker's compensation pamphlet to better understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.

MEDICARE

_____ I am a Medicare participant and will pay for services as they are rendered. I understand that your office does not accept assignment of benefits for Medicare but will submit all charges to Medicare for me. I have read and signed the Medicare Act form and fully understand what services are covered.

X____________________________________ **DATE:** ____________________

(Signature of Insured/Claimant)

____

(Signature of Witness)