Mark E. Dailey DC, CFMP

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www.birminghamlifechangingcare.com

CONFIDENTIAL PERSONAL DATA

DATE_____ PATIENT NAME _____ SEX M F

DATE OF BIRTH _____ RACE _____ *Decline* Are you of Hispanic or Latino descent? Yes No *Decline*

PREFERRED LANGUAGE _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY #_____ MARITAL STATUS: _____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

E-MAIL _____ HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE _____

POLICY #_____ GROUP# _____

DO YOU HAVE A SECONDARY INSURANCE? _____ NAME _____

POLICY #_____ GROUP# _____

IF YOUR SPOUSE OR PARENT IS THE SUBSCRIBER ON YOUR INSURANCE PLEASE GIVE US THEIR:

NAME: _____ DATE OF BIRTH: _____

IF YOU DO NOT HAVE INSURANCE HOW WILL YOU PAY: CASH_____CHECK_____ CREDIT CARD_____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT? _____

CONSENT OF PROFESSIONAL SERVICES

I hereby authorize Mark E. Dailey, D.C., C.F.M.P. and whomever he designates as his assistant to administer chiropractic care as he deems necessary in my case, and I further consent to any physical examination, X-ray study, laboratory procedures, chiropractic or adjunctive therapy, or clinic service that is ordered under the general and specific instructions of the doctor.

RELEASE OF INFORMATION

I hereby authorize the release of any information acquired in the course of my history, examination and or treatment necessary for the collection of all or part of the clinic's charges.

FINANCIAL AGREEMENT

I, the undersigned, hereby agree to pay Mark E. Dailey, D.C., C.F.M.P. all amounts and charges hereafter incurred by myself and by members of my family for products and services rendered to myself/them. The amount shown on the books and records of Dr. Mark E. Dailey shall be due upon demand and to secure payment, agree to pay all costs of collections including attorney fees and court costs and wave my exemption rights under the constitution and laws of the State of Alabama.

_____ _____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY **DATE** **WITNESS**

Mark E. Dailey, D.C., C.F.M.P.

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks and most credit cards. We will be happy to help you process your insurance claim forms for your reimbursement. Any such request must be accompanied by a complete insurance form at each visit. In SPECIAL instances we may accept assignment of insurance benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1-1/2% per month. Charges of $20 may also be made for broken appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance.

You must realize, however, that:

1. Because your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of UCR. "UCR" is defined as "Usual, Customary and Reasonable" fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as chiropractic care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

_____

Signature of Patient or Responsible Party

_____ _____

Patient Name **Date**

CURRENT COMPLAINT HISTORY

Patient Name: _____ Date: _____ Completed By: Patient

(1) _____ _____ _____ _____ _____

Main Complaint | How long ago did it start | Was it Sudden or Gradual | How long has it lasted | How many times has it happened

(Describe how it started): _____

What makes it feel better: (Nothing, Positions, Activity, Time of Day, Home or Store Remedies) _____

What makes it hurt worse: (Nothing, Positions, Activity, Time of Day, Coughing, Sneezing, Straining) _____

Describe the type of pain you feel: (Dull, Sharp, Burning, Stabbing, Achy, Gnawing, Throbbing, Shooting, Constricting) _____

Does the pain move to another part of your body: No -- (R/L Shoulder, Arm, Elbow, Forearm, Fingers, Front/Back) -- (R/L Buttock, Hip, Thigh, Knee, Leg, Ankle, Foot, Toes, Front/Back): _____

Severity: Mild, Moderate, Severe **Timing:** Comes and Goes, Sometimes, Frequent, Constant **Do you wake up with complaint:** _____

Better: Morning, Afternoon, Evening, Nighttime, None **Worse**: Morning, Afternoon, Evening, Nighttime, None _____

(2) _____ _____ _____ _____ _____

Secondary Complaint | How long ago did it start | Was it Sudden or Gradual | How long has it lasted | How many times has it happened

(Describe how it started): _____

What makes it feel better: (Nothing, Positions, Activity, Time of Day, Home or Store Remedies) _____

What makes it hurt worse: (Nothing, Positions, Activity, Time of Day, Coughing, Sneezing, Straining) _____

Describe the type of pain you feel: (Dull, Sharp, Burning, Stabbing, Achy, Gnawing, Throbbing, Shooting, Constricting) _____

Does the pain move to another part of your body: No -- (R/L Shoulder, Arm, Elbow, Forearm, Fingers, Front/Back) -- (R/L Buttock, Hip, Thigh, Knee, Leg, Ankle, Foot, Toes, Front/Back): _____

Severity: Mild, Moderate, Severe **Timing:** Comes and Goes, Sometimes, Frequent, Constant **Do you wake up with complaint:** _____

Better: Morning, Afternoon, Evening, Nighttime, None **Worse**: Morning, Afternoon, Evening, Nighttime, None _____

(3) _____ _____ _____ _____ _____

Minor Complaint | How long ago did it start | Was it Sudden or Gradual | How long has it lasted | How many times has it happened

(Describe how it started): _____

What makes it feel better: (Nothing, Positions, Activity, Time of Day, Home or Store Remedies) _____

What makes it hurt worse: (Nothing, Positions, Activity, Time of Day, Coughing, Sneezing, Straining) _____

Describe the type of pain you feel: (Dull, Sharp, Burning, Stabbing, Achy, Gnawing, Throbbing, Shooting, Constricting) _____

Does the pain move to another part of your body: No -- (R/L Shoulder, Arm, Elbow, Forearm, Fingers, Front/Back) -- (R/L Buttock, Hip, Thigh, Knee, Leg, Ankle, Foot, Toes, Front/Back): _____

Severity: Mild, Moderate, Severe **Timing:** Comes and Goes, Sometimes, Frequent, Constant **Do you wake up with complaint:** _____

Better: Morning, Afternoon, Evening, Nighttime, None **Worse**: Morning, Afternoon, Evening, Nighttime, None _____

Any changes in bodily function:
(None) (Urination, Defecation, Respiration, Digestion, Vision)

_____

_____

_____

Any other complaints in any other part of body: _

_____

_____

_____

Previous Surgery, Falls & Accidents: _____

_____

_____

_____

_____

_____

Names of other Doctors: _____

_____

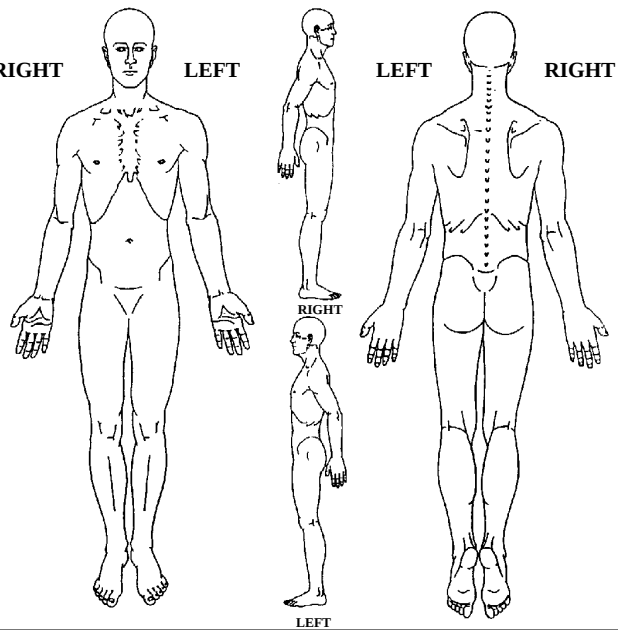
Other: (Medications, Therapies, Etc.) _____

_____

_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF PAIN

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES **S** = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



Dr. Notes:

Initial: _MED_

The Wellness Center • 1901-B 2nd Avenue East Oneonta, AL 35121

Mark E. Dailey DC, CFMP • Dailey Chiropractic Wellness Center

PATIENT HEALTH HISTORY

PATIENT NAME _____ DATE_____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT_____

PAST CHIROPRACTIC CARE ____ YES ____NO DOCTORS NAME _____

Are your present problems due to an injury? ____Yes ____No If no you may skip this section.
If yes: _____On job _____Auto Accident _____Personal Injury _____Other
Has the accident been reported? _____ Yes _____ No
If yes: _____To employer ____ Auto carrier _____Other:_____
Are you now or have you ever been disabled? (Service or Work) _____Yes _____No When?_____
Have you retained an attorney? ____Yes ____No
If yes: Name & Address of Attorney_____

What is your current work status?

____Full time ____Part time ____ Not employed ____ Full time student ____Retired

Are you on any work restrictions? _____ Yes _____ No
If yes: ___ Off work due to restrictions or ____ On Light Duty From _____ to _____
Do/did you require outside help at home? ____Yes ____No

List any accidents or falls and their dates:

Auto_____
Recreation_____
Sports_____
Work Related_____

List any broken bones(fractures) or dislocations:_____

Ever on crutches ____Yes ____No If yes, why?_____
If you were ever knocked unconscious please explain_____
Have you ever had X-rays taken? ____Yes ____No When?_____ By whom?_____
For what were the X-rays taken?_____
Do you wear orthotics or heel lifts? _____Yes _____No Fitted by Whom?_____
Do you presently suffer from any condition other than that for which you are now consulting us? Yes No
Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins/minerals or etc? ____ Yes ____ No
Please list:_____
_____
_____
_____

Operations and Procedures

Hospitalized? _____ Yes _____No List Date and Reason _____
_____
_____
Back operation? ____ Yes ____ No Date_____
Spinal Taps/Injections? ____ Yes ____ No Date_____
Sinus? ____ Yes _____No Date:_____
Hernia? ____ Yes _____ No Date:_____
Have you ever had any operations or surgeries _____Yes _____ No

General Symptoms:

Headaches _____ Yes _____No
Numbness or Pain in: Arms ____Yes ____No Legs ___ Yes ___ No Hands ____Yes ____ No
Allergies____Yes ____ No What?_____

Muscles/Joints:

Backache ____ Yes ____ No Foot Trouble ____Yes ____No Hernia ____Yes ____No
Pain between shoulders ____Yes ____No Painful Tailbone ____Yes ____No Stiff Neck ____Yes ____No
Spinal curvature ____Yes ____No Swollen Joints ____Yes ____No Tremors ____Yes ____No

Cardio-Vascular:

High Blood Pressure ____Yes____No Low Blood Pressure ____Yes___No Chest Pain____Yes____No
Strokes ____Yes ____ No Swelling Ankles ____Yes ____No Varicose Veins ____Yes ____No
Heart Trouble ____Yes ____No **Do you have a pacemaker? _____Yes _____No**

For women only: Are you presently pregnant? ___Yes ___No Date of last period?_____

Family History:	**Diabetes**	**Kidney**	**Cancer**	**Back**
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Brothers/Sisters	_____	_____	_____	_____

Habits: Smoking ____Yes ____No Have you ever smoked? _____ Yes _____No

Drink Alcohol ____Yes ____No Caffeine ____Yes ____No

How much water do you drink daily? _____Cups/Ounces

Exercise: ___None ___Moderate ___Daily Type:_____

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider **will/will not** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature_____ **Date**_____