Dr. Adam Edge
4961 Cemetery Road
Hilliard, OH 43026
P (614)527-1776 F (614)527-1774

NEW PATIENT INFORMATION

PATIENT INFORMATION:

NAME: _____ DATE:_____
BIRTHDATE_____-_____-_____ AGE:_____ M___ F___ PHONE #:_____ CELL/HOME
ADDRESS:_____ CITY:_____STATE_____ZIP CODE_____
SS# _____ * EMAIL_____
* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions
EMPLOYER NAME/ADDRESS:_____
EMPLOYER PHONE:_____OCCUPATION:_____

MARITAL STATUS: _____Single _____Married _____Widowed _____Divorced
SPOUSE NAME:_____DATE OF BIRTH: _____
SPOUSE MOBILE #:_____ SPOUSE OCCUPATION: _____
EMERGENCY CONTACT NAME:_____
RELATIONSHIP_____ PHONE #_____

INSURANCE INFORMATION:

DO YOU HAVE MEDICARE? _____YES _____NO IF YES, MEMBER ID#_____
DO YOU HAVE HEALTH INSURANCE? _____YES _____NO
PRIMARY INS COMPANY_____ MEMBER/POLICY #_____
SECONDARY INS COMPANY_____ MEMBER/POLICY #_____

HISTORY OF COMPLAINT:

Please identify the condition(s) that brought you to our office:

1st._____ 2nd._____3rd._____

On a scale of 0-10 (0= no pain and 10= worst pain), rate your *above* complaints, by checking the number that applies:

1st. _____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

2nd. _____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

3rd. _____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

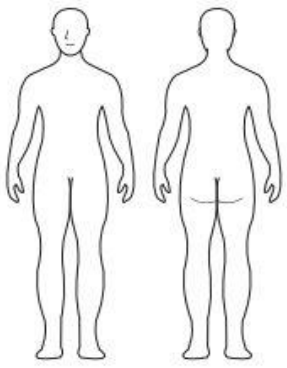
When did the complaint(s) begin?_____ When is the complaint(s) the worst? _____AM _____Mid-Day _____PM

How did the "injury" (complaint) happen?_____

How long does it last? ___It is constant ___I experience it on and off during the day ___It comes and goes throughout the week

DESCRIBE YOUR SYMPTOMS:

Mark the areas on the diagram with the following letters:
R= Radiating B= Burning D= Dull A=Aching N=Numbness
S=Sharp/Stabbing T=Tingling



PAST HISTORY:

1. Have you suffered with this or a similar problem in the past? ___ No ___Yes – If yes, How many times?_____
When was the last episode? _____ How did the injury happen?_____
2. Other forms of treatment tried? ___ No ___ Yes – If yes, please state what type of treatment: _____ and who provided treatment: _____ How long ago? _____ What were the results? ___Favorable ___ Unfavorable – Please explain:_____
3. Have you ever seen a chiropractor? ___ No ___Yes – If yes, what were the results? ___Bad ___ Good ___ Great

ACTIVITIES OF DAILY LIVING:

1. No effect 2. Painful (can do)
3. Painful (activities limited) 4. Unable to perform

Bending	☐ 1	☐ 2	☐ 3	☐ 4
Carrying	☐ 1	☐ 2	☐ 3	☐ 4
Climbing	☐ 1	☐ 2	☐ 3	☐ 4
Computer work	☐ 1	☐ 2	☐ 3	☐ 4
Concentrating	☐ 1	☐ 2	☐ 3	☐ 4
Dancing	☐ 1	☐ 2	☐ 3	☐ 4
Doing Chores	☐ 1	☐ 2	☐ 3	☐ 4
Dressing	☐ 1	☐ 2	☐ 3	☐ 4
Driving	☐ 1	☐ 2	☐ 3	☐ 4
Gardening	☐ 1	☐ 2	☐ 3	☐ 4
Lifting	☐ 1	☐ 2	☐ 3	☐ 4
Playing Sports	☐ 1	☐ 2	☐ 3	☐ 4
Pushing	☐ 1	☐ 2	☐ 3	☐ 4
Reading	☐ 1	☐ 2	☐ 3	☐ 4
Recreational Activities	☐ 1	☐ 2	☐ 3	☐ 4
Rolling Over	☐ 1	☐ 2	☐ 3	☐ 4
Running	☐ 1	☐ 2	☐ 3	☐ 4
Sexual Activity	☐ 1	☐ 2	☐ 3	☐ 4
Shoveling	☐ 1	☐ 2	☐ 3	☐ 4
Sitting	☐ 1	☐ 2	☐ 3	☐ 4
Sitting to Standing	☐ 1	☐ 2	☐ 3	☐ 4
Sleeping	☐ 1	☐ 2	☐ 3	☐ 4
Standing	☐ 1	☐ 2	☐ 3	☐ 4
Walking	☐ 1	☐ 2	☐ 3	☐ 4
Watching TV	☐ 1	☐ 2	☐ 3	☐ 4
Working	☐ 1	☐ 2	☐ 3	☐ 4

ADDITIONAL HISTORY:

Please check all that apply in past 12 months.

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Blood Pressure (High or Low)
- ☐ Blurred Vision
- ☐ Broken Bones/Fractures
- ☐ Cancer
- ☐ Colon Trouble/Digestive Issues
- ☐ Depression
- ☐ Diarrhea/Constipation
- ☐ Difficulty Breathing
- ☐ Dizziness/Loss of Balance
- ☐ Double Vision
- ☐ Eating Disorder
- ☐ Epilepsy/Convulsions
- ☐ Fainting
- ☐ Foot or Knee Problems
- ☐ Frequent Colds/Flu
- ☐ Gall Bladder Trouble
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heartburn
- ☐ Heart Problem
- ☐ Hepatitis (A,B,C)
- ☐ Hormone Imbalance
- ☐ Impotence/Sexual Dysfunction
- ☐ Irritable
- ☐ Jaw pain/TMJ
- ☐ Kidney Trouble
- ☐ Learning Disability
- ☐ Liver Trouble
- ☐ Lung Problems
- ☐ Menopausal Problems
- ☐ Mood Changes
- ☐ Numb/Tingling arms, hands, fingers
- ☐ Numb/Tingling legs, feet, toes
- ☐ Osteoporosis
- ☐ Pain CHEST
- ☐ Pain HIP
- ☐ Pain LOW BACK
- ☐ Pain MID BACK
- ☐ Pain NECK
- ☐ Pain SHOULDER
- ☐ Pain UPPER BACK
- ☐ Painful Swollen joints
- ☐ Pregnant (now)
- ☐ Prostate Problems
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Sinus/Drainage Problem
- ☐ Skin Problems
- ☐ Swollen/Painful Joints
- ☐ Tremors
- ☐ Trouble Sleeping
- ☐ Tumors
- ☐ Ulcers

FAMILY HISTORY:

1. Does anyone in your family suffer with the same complaint(s)? ☐ No ☐ Yes
   If Yes, whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
2. Have they ever been treated for the same condition(s)? ☐ No ☐ Yes ☐ I don't know
3. Any other hereditary conditions the Doctor should be aware of? ☐ No ☐ Yes: If yes, Explain: _____

SOCIAL HISTORY:

1. Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes >> How often: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverages (Consumption): >> How often: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use: >> How often: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? _____
   _____

ARE YOU TAKING MEDICATIONS FOR ANY OF THE FOLLOWING:

❑ Acid Reflux	❑ Anxiety	❑ Cholesterol	❑ Hormone Therapy (HRT)	❑Thyroid
❑ ADD/ADHD	❑ Aspirin	❑ Crohns/Colitis	❑ Ibuprofen	❑Tylenol
❑ Allergy	❑ Birth Control	❑ CPAP machine	❑ Muscle Relaxer	❑_____
❑ Anti-biotics	❑ Blood Pressure	❑ Diabetes	❑ Pain Killer	❑_____
❑ Antidepressants	❑ Blood Thinner	❑ Headache	❑ Sleep	❑_____

WOMEN ONLY: **Currently Pregnant?** □ Yes □No **Painful /Abnormal Menstrual Cycle?** □ Yes □ No **Menopause?** □ Yes □ No **Miscarriage?** □ Yes □ No **Do you have children?** □ Yes □ No **If "Yes",**type of birth? **Circle** Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

Family Doctor Name_____ **Phone** _____

Address_____

May we contact him/her: _____Yes _____No

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

Disclosure & Consent
Chiropractic Adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. Comparison Risks are Being Struck by Lightning 1:700,000, Drowning in Bathtub 1:818,015, Fatally Falling Down Stairs 1:565,700, Accidentally Suffocation in Bed 1:565,700, Cerebral Vascular Accident 1: 5.85 Million and Cauda Equina Syndrome: 1:1 Hundred Million. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, And all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek.

To be completed by patient:

Print Name *_____Signature of patient *_____ Date _____

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapacitated:

Print name of patient if minor _____ Date _____

Print name of patient's representative _____as: _____
Relationship or authority of patient's representative

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____ (patients name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Family Chiropractic, which describes the Practices policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Signature *_____ Date _____

Print Name _____

Ways in Which We May Communicate With You:

Leave Messages at: □ Home □ Work □ Cell □ Voicemail (work) □ Answering Machine (home)
□ Mail information to your home

Would you like to receive appointment reminders through e-mail or text? (Circle one) Email Text _____
If text, please list carrier name. Example: ATT 10digitphonenumber@txt.att.net)

To whom may we speak to about your medical concerns? (Please specify names)

1.)_____ 2.)_____ 3.) _____

Family Chiropractic – Hilliard, Ohio
Financial Policy

Whether you are new to Family Chiropractic or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies.

Providing high quality medical care to you and your family is a matter of personal satisfaction for each one of us. When you or your family member requires chiropractic care, we are happy to take care of your needs. When you utilize our services, you are responsible for the costs incurred. Understanding our financial policies is an essential element of your care and treatment. If you have any questions regarding our policy, please feel free to discuss them with our staff.

PATIENTS WITH COMMERCIAL INSURANCE, MEDICARE AND MEDICAID:
Please understand, as health care providers, our relationship is primarily with you, not your insurance company. As a courtesy and convenience to you, we will file claims for all our patients. We cannot bill your insurance company unless you give us current, accurate insurance information. You can help us by:

1. Bring your insurance card. (update staff with any changes to your insurance)
2. Paying your co-payment /deductible at time of service.
3. Contacting our office if you have any questions regarding your account (we can be reached at 614-527-1776 Monday through Thursday 8:00am to 4:00pm).
4. Making sure we have your current address and phone number when there are changes.

If your insurance has an outstanding deductible which has not been paid, you will be asked to pay the portion of the deductible which pertains to the services of Family Chiropractic.

Not all insurance plans cover all services. In the event your plan determines a service to be "not covered" you will be responsible for the complete charge. If you benefits have expired during the course of your care with us, you will be responsible for full payment of the charges incurred.

SELF PAY PATIENTS: You are responsible for full payment of charges at the time of your first visit. Our staff with give you an estimate of the charges so you can be prepared to pay. Our office staff with work with you to determine a payment plan for subsequent charges.

DISMISSAL FROM THE PRACTICE: Our staff with work closely with you to help you meet your financial obligations to Family Chiropractic. However, if you do not pay your balance according to the arranged plan, your account with be turned over to a collection agency and you will be dismissed from the practice. A certified letter will be sent informing you of the action. Patients who are dismissed from the practice will be unable to make appointments with Family Chiropractic. In order to be reinstated, any outstanding balance as well as an administrative fee must be paid in full.

METHOD OF PAYMENT: We accept cash, checks, and VISA, MasterCard and debit cards. For your convenience and with your authorization, we will automatically charge your credit card for any outstand balance remaining after insurance has paid. (See Payment policy) Please note that we do not accept post-dated checks, nor will we hold checks for any length of time.

I have read the above and understand my financial responsibility. I understand that no guarantees have been made to me about my insurance coverage and I do not hold Family Chiropractic or Dr. Adam Edge or staff responsible for my insurance coverage. I understand that I am responsible for payment for the services provided by Family Chiropractic.

*_____ _____

Patient Signature/Date **Patient Name (print)**

Family Chiropractic Centers
Dr. Adam Edge
4961 Cemetery Road Hilliard, Oh 43026 Phone (614) 527-1776 / Fax (614)527-1774

Payment Policy and Credit/Debit Card Authorization

If You Do Not Have Insurance:
We have a Time of Service payment schedule that has a required payment same day of service. We accept cash, personal check, Visa and MasterCard.

For Our Contracted Insurance Plans:
If your insurance carrier requires you to pay a pre-determined co-payment/deductible, you will be expected to pay this amount on day of service. Additionally, you will be asked to have your credit card information on file to cover any portion of your bill that is your responsibility as determined by your insurance carrier.

Non-Contracted Insurance Plans:
IF WE ARE ABLE TO VERIFY ELIGIBILITY AND IN-NETWORK OR OUT-OF-NETWORK COVERAGE you will be asked to pay any pre-determined co-payment/deductible. We will courtesy file each claim with your insurance carrier and follow the insurance carriers EOB determination of the claim(s). Additionally, you will be asked to have your credit card information on file to cover any portion of your bill that is your responsibility as determined by your insurance carrier.

Not all insurance plans cover all services. In the event your plan determines a service to be "non-covered" you will be responsible for the complete charge. If your benefits have expired during the course of care with us, you will be responsible for full payment of the incurred charges.

NO HASSLE PAYMENT METHOD

Please complete your authorization to bill a major credit or debit card listed below. This will cover any charges that are determined to be your responsibility per your insurance company. All credit/debit card information will remain absolutely confidential.

Card Holder Name (as presented on card)_____
Card Number:_____ Expiration:_____ Vcode: _____
Card Type: _____ Credit _____ Debit _____ Visa _____ MasterCard

Billing Address:_____

Cardholder signature:_____ Date:_____
I hearby authorize Family Chiropractic Centers to charge the indicated credit/debit card for any and all outstanding balances, after insurance carrier reimbursement or denial. I guarantee and warrant that I am the legal cardholder for this credit/debit card and that I am legally authorized to enter into this agreement with Family Chiropractic Centers. I understand that I will not receive a statement if there is not balance due after processing my credit/debit card for payment.

By checking this box, you are authorizing Family Chiropractic to email receipt copy ☐
Email Address:_____