CORRECT CARE FAMILY CHIROPRACTIC

Eat Well • Move Well • Think Well

PT. #_____

Date:_____

Name	Preferred Name			
Address & Street		Sex ☐ Male ☐ Female		
City, State, Zip	Phone	Date of Birth	Age	
☐ Married ☐ Widow ☐ Single ☐ Divorced	Health Insurance ○ Yes ○ No Primary _____ Secondary _____	Alternate Phone		
		E-Mail Address		
No. of Children	Ages			
Occupation	Employer	Work Phone No. ( )		
Is this appointment for a particular symptom or for wellness care? Please explain:		Preferred contact ☐ work ☐ home ☐ cell		
Emergency Contact	Relationship	Phone ( )		
Referred by	Have you had chiropractic care before? ☐ Yes Where? ☐ No	Are you here because of a recent: ☐ on the job injury ☐ an auto accident		

Have you ever had any falls, accidents or injuries? ☐ Yes ☐ No If needed use space below	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
Have you ever had surgery? ☐ Yes ☐ No If needed use space below	MONTH, YEAR	TYPE OF SURGERY	COMMENTS
Any prior or present illnesses? ☐ Yes ☐ No	MONTH, YEAR	TYPE OF ILLNESS	COMMENTS

Are you presently taking medication? ☐ Yes ☐ No If needed use space below	NAME OF DRUG	DOSES PER DAY	NAME OF DRUG	DOSES PER DAY

Is it possible you are pregnant? ☐ Yes ☐ No

Please check any of the following that give you difficulty. ☑

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hayfever
- ☐ Asthma
- ☐ Loss of Taste
- ☐ Inflammation of throat
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred Vision
- ☐ Lights bother eyes
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grinding in neck
- ☐ Tightness of shoulders and arms
- ☐ Pain in shoulders and arms
- ☐ Pins and needles in arms & hands
- ☐ Ear ache
- ☐ Numbness in arms / hands
- ☐ Cold hands / fingers
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves and nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Low back pain
- ☐ Ulcers
- ☐ Numbness in legs or feet
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps and pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Pins and needles in legs
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pains in legs and feet

Please indicate which activities of daily living are affected by your present complaints

General	☐ Walking	☐ Sleeping	☐ Playing piano	☐ Using keyboard
	☐ Sitting	☐ Standing	☐ Using a telephone	☐ Exercising
	☐ Climbing Stairs	☐ Lifting children	☐ Running	☐ Sitting in recliner
	☐ Chewing	☐ Reading	☐ Bending	☐ Getting into/out of an automobile
	☐ Kneeling	☐ Swimming	☐ Lying in bed	
Housework	☐ Doing Laundry	☐ Vacuuming	☐ Ironing	☐ Caring for pets
	☐ Making beds	☐ Washing dishes	☐ Carrying groceries	☐ Cooking
Yardwork	☐ Mowing Lawn	☐ Raking leaves	☐ Gardening	☐ _____
Personal Grooming	☐ Combing hair	☐ Shaving	☐ In/out bathtub	☐ Brushing teeth
Travel	☐ Driving a car	☐ Riding in a car	☐ _____	☐ _____

NOTE: It is understood and agreed the amount paid Correct Care Chiropractic for x-rays is for examination only and the x-ray negatives will remain in the property of this office, being on file where they may be seen while a patient of this office.

Signature:_____ Date:_____

To avoid bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

Doctor's Use Only

P.O.P. / P.D. / P.S. (F.A.) / F.T. / L.O.T. / D.O.C. / H.P. / A.E.P. / N.L.W.

COMMENTS _____

SECONDARY COMPLAINT _____

A- 5/6/4 B- 3/5/4 C- 2/5/4 1/5/4 -C 0/2/5 -C _____OTHER

Eat Well · Move Well · Think Well Dr. James Kravis, D.C., Director

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Correct Care Chiropractic and hereby release you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Correct Care Chiropractic any monies due them on account, the same to be deducted from any settlement made on my behalf. Further, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

ACKNOWLEDGEMENT OF PROTECTED HEALTH INFORMATION PRACTICES: It is understood that by Federal Law, my personal health information is protected. This office has available for review its Health Privacy Policy regarding the sharing of that information. Should I have any questions regarding this policy, I will contact this office.

TERMS OF ACCEPTANCE: It is understood that the chiropractic care received in this office is not meant to diagnose or treat any disease or condition other than vertebral subluxation.

CONSENT TO CARE FOR A MINOR: I hereby authorize Correct Care Chiropractic to administer care as deemed necessary to: _____ Relationship: _____ D.O.B _____

ACKNOWLEDGEMENT OF SPECIAL PROMOTIONAL FEE: I acknowledge that this fee (_____) is a special promotion at Correct Care Chiropractic and does not reflect their normal and customary charges for services. I expect to receive no further notice of this policy.

ACKNOWLEDGEMENT OF X-RAY FEES: It is understood and agreed the amount paid to Correct Care Chiropractic for x-rays is for examination & interpretation only. I understand that there is a copy charge for x-ray or record copies.

_____ _____

Patient Name Patient Signature

_____ _____

Date Witness

Insurance and Payment Policies

- All estimated co-pay/coinsurance amounts are due at the time of service.
- All products and services not covered by insurance must be paid in full at the time of service.
- All services that are subject to deductible will be billed to insurance. Once the insurance carrier has processed the claim, any balance owed must be paid in full upon receipt of statement.
- Any disputed balances will be reviewed by our billing service. Once the balance has been confirmed, the balance owed must be paid in full upon receipt of statement.
- We will attempt to confirm all insurance benefits prior to your visit. If benefits cannot be confirmed, cash fees will apply.
- In cases where an insurance carrier's fee schedule cannot be determined, all estimated coinsurance amounts will be based on our full fees.
- If you have used all of your insurance benefits for your policy year, you will have the option of paying our current cash fees or purchasing a prepaid care package.
- Balances past 30 days due will be transferred to Transworld Systems for collection. Once your account is placed in collection, no further care will be rendered until the balance is paid in full and all future care must be paid at the time of service or guaranteed with a credit card.

I have read and understand the above policies.

Patient Name _____ Patient Signature _____

Date _____ Witness _____

Name:_____ Date:_____

Do you have allergies to any Medications? Yes ____ No _____. If yes, please fill out the attached sheet.

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Race: African/African American _____ Asian/Asian American _____ Caucasian/European American _____
Native American/Native Alaskan _____ Native Hawaiian/Other Pacific Islander _____ Other _____

Preferred Language: _____

Smoking Status: (13years or older)
_____ Current every day smoker
_____ Current some day smoker
_____ Former smoker
_____ Never smoked

Medicare patients only: Do you also have Medicaid? Yes _____ No_____

Doctors Use Only

2 years or older: Blood Pressure: _____/_____ Pulse: _____/minute

Height/length _____inches Weight _____lbs. Body Fat %_____ BMI _____

Head circumference (0-3 years old) _____inches.

Growth Chart: 0-3 years old Height ____% Weight _____% 3-20 years old Height: _____% Weight _____%

Medication Allergic Reactions

Patient Name:____
Date:________________________

Medication Name:____________________________________

Please check your reactions to this medication:

Rash: Local___ General ___
Itching ___
Swelling: Skin ___ Face ___
Hives ___
Red eyes ___
Runny nose ____
Cough ____
Abdominal Pain/Cramps___

Bloating/Gas ____
Vomiting ___
Diarrhea ____
Nausea ____
Shortness of Breath____
Wheezing ____
Swelling of Tongue ____
Trouble speaking ____

Trouble Swallowing ____
Trouble Breathing ____
Dizzy/lightheaded ____
Blackouts ____
Chest pain ____
Irregular heart beat ____
Fast heart beat ____
Slow heartbeat ____

Medication Name:____________________________________

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Chest pain ____
Irregular heart beat ____
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