GILLIS Chiropractic Clinic

Dr. J. Scott Gillis
Chiropractic Physician

Please present valid identification and your insurance card to the front desk staff. All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

PATIENT DEMOGRAPHICS

Today's Date: _____

Patient Name: _____ □ Male □ Female

What you prefer to be called: _____

DOB: _____ Age: _____ SSN: _____

Home Address: _____
Street

_____
City *State* *Zip Code*

Phone Number: _____ Work Number: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Race: □ American Indian/Alaska Native □ Asian □ African American □ Native Hawaiian □ Other Pacific Islander □ White

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Occupation: _____

Place of Employment: _____

How did you hear about us? □ Referred by (Name): _____

□ Other: _____

INSURANCE INFORMATION

Please present insurance card to the front desk staff.

REASON FOR VISIT

Have you ever been treated by a chiropractor before? □ Yes □ No

If so, please explain when and why: _____

The reason for this visit is a result of: □ Work □ Sports □ Auto □ Trauma □ Chronic

Explain what happened: _____

_____

_____

Describe the pain and location: _____

When did the condition begin? _____

Is the condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is the condition interfering with your: □ Work □ Sleep □ Daily Routine

Have you had this or similar conditions in the past? □ Yes □ No

If yes, please explain: _____

Have you been treated by a Medical Physician for this condition? □ Yes □ No

Indicate your degree of comfort while performing the following activities:

Activity	Comfortable	Uncomfortable	Painful (even if only sometimes)
Lying on Back	□	□	□
Lying on Side	□	□	□
Lying on Stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Stretching	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

How many hours are in your normal workday? _____

Please indicate any physical activity you are required to perform:

□ Standing	□ Twisting	□ Lifting
□ Sitting	□ Typing	□ Working w/ arms above head
□ Crawling	□ Stooping	□ Others:
□ Bending	□ Operating Equipment	□
□ Driving	□ Walking	□

Do you work with others that can help with heavy lifting? □ Yes □ No □ N/A

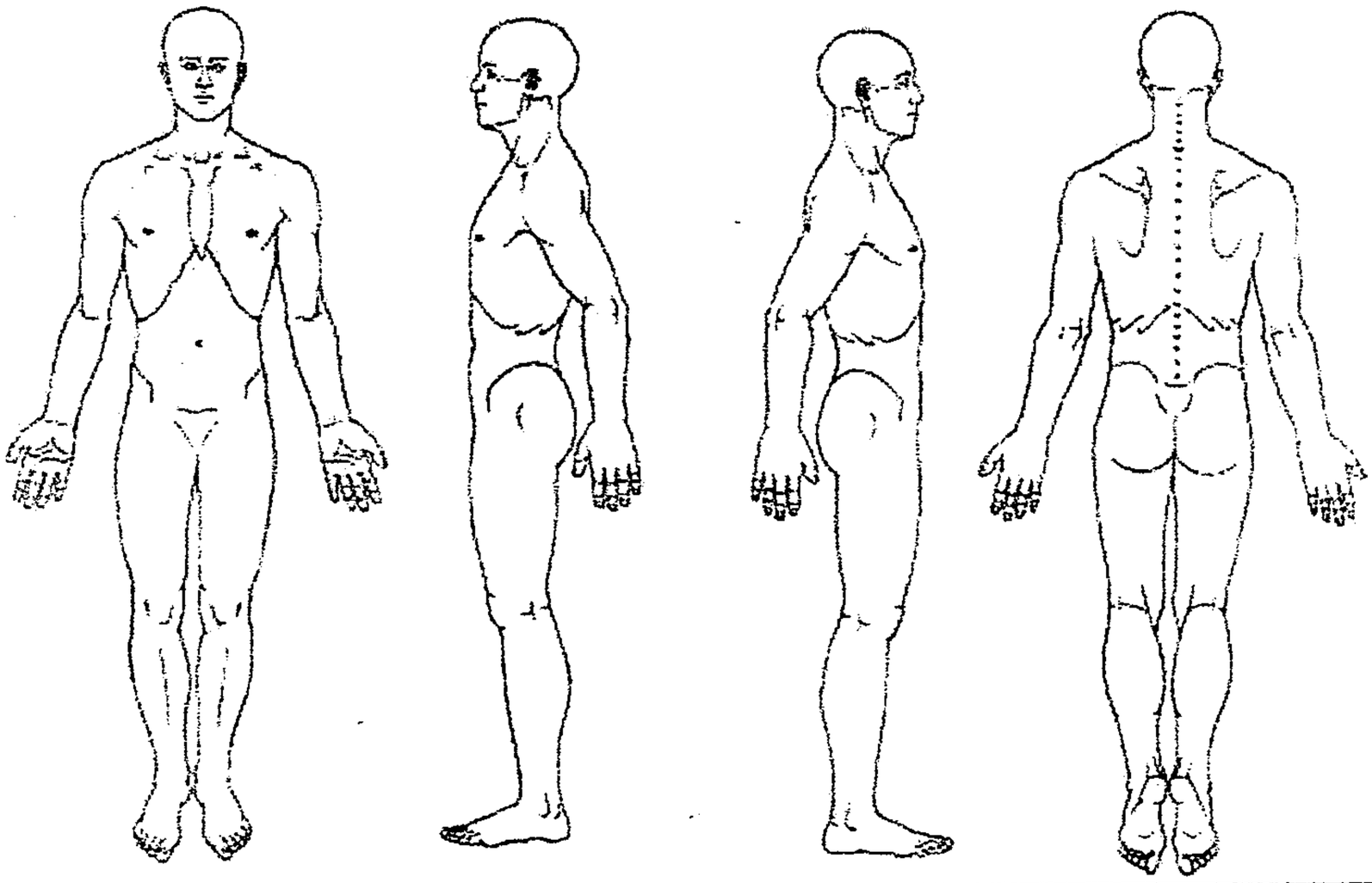
Is there any light duty work you could request? □ Yes □ No □ N/A

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description: Numbness Pins & Needles Burning Aching Stabbing
Symbol: (N) (P) (B) (A) (S)

Circle any area of pain not represented by a symbol



Patient Remarks: _____

_____

_____

Doctor's Remarks: _____

_____

_____

_____

Side / Back / Stomach Sleeper Firm / Semi / Soft W/ Pillow Weather Bothers

Heat / Ice Rx: _____ X/Day: _____

Worse Certain Time of Day / AM/PM Positional / Lying / Sit / Stand / Walk

What Relieves Pain if Anything: _____

_____

_____

PATIENT HEALTH HISTORY

Height: _____ Weight: _____

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers (Including Aspirin) □ Muscle Relaxers □ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Other: _____

Have you ever had any of the following diseases/medical condition(s)?

□ Heart Attack/Stroke	□ Pacemaker	□ Heart Murmur
□ Congenital Heart Disease	□ Mitral Valve Prolapse	□ Artificial Valves
□ Alcohol/Drug Abuse	□ STD	□ Hepatitis
□ HIV+/AIDS	□ Shingles	□ Cancer
□ Frequent Neck Pain	□ Emphysema/Glaucoma	□ Anemia
□ High/Low Blood Pressure	□ Psychiatric Problems	□ Rheumatic Fever
□ Severe/Frequent Headaches	□ Kidney Problems	□ Ulcers/Colitis
□ Fainting/Seizures/Epilepsy	□ Sinus Problems	□ Asthma
□ Diabetes/ Tuberculosis	□ Difficulty breathing	□ Chemotherapy
□ Lower Back Problems	□ Artificial Bones/Joints	□ Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

_____

_____

Please list anything you may be allergic to: _____

_____

_____

Please list any previous surgeries/treatments with dates: _____

_____

_____

Please list any past serious accidents with dates: _____

_____

_____

Do you smoke? □ Yes □ No How much? _____ How Long? _____

Are you wearing any of the following? □ Heels □ Lifts □ Sole lifts □Inner Soles □ Arch Supports

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No How Long? _____

PERSONAL INJURY CASE

Patient Claim Number: _____ Auto Insurance: _____

Auto Policy Number: _____

Insurance Address: _____

Street *City* *State* *Zip Code*

Insurance Phone: _____ Fax: _____

Agent's Name: _____

Attorney's Name: _____

Attorney Phone: _____ Fax: _____

Liable Party Auto Insurance: _____

Auto Policy Number: _____

Insurance Address: _____

Street *City* *State* *Zip Code*

Insurance Phone: _____ Fax: _____

Agent's Name: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Were you the: □ Driver □ Pedestrian □ Front Passenger □ Rear Passenger

Make & Model of the vehicle you were occupying: _____

What did your vehicle impact? □ Another vehicle □ Other: _____

If another vehicle, what was its make and model? _____

Did the police come to the accident site? □ Yes □ No

Were there any witnesses? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No

Was the vehicle equipped with airbags? □ Yes □ No

If yes, did it/they inflate? □ Yes □ No

In relation to the base of your skull, where was the headrest? □ Above □ Below □At the Base of Skull

Did any part of your body strike anything in the vehicle? □ Yes □ No

If yes, please describe: _____

In which direction were you headed: □ North □ South □ East □ West

What was the approx.. speed of your vehicle? _____

In which direction was the other vehicle headed? □ North □ South □ East □ West

What was the approx.. speed of the other vehicle? _____

Did the impact to your vehicle come from the: □ Left Side □ Right Side □ Front □ Rear □ Other

During impact, were you facing: □ Right □ Left □ Forward

Were you aware or surprised by the impact? □ Aware □ Surprised

In your words, please describe the accident:

_____

_____

Did the accident render you unconscious? □ Yes □ No

If so, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any doctor? □ Yes □ No

When did you go? □ Just after the Accident □ the next day □ 2 days plus

How did you get there? □ Ambulance □ Private Transportation

Name of the Hospital and/or Attending doctor: _____

Describe any treatment you received: _____

Were X-Rays taken? □ Yes □ No

Was medication prescribed? □ Yes □ No

Have you been able to work since this injury? □ Yes □ No

Are your work activities restricted since this injury? □ Yes □ No

Indicate the symptoms that are a result of this accident:

□ Dizziness	□ Upset Stomach	□ Numb Hands
□ Nausea	□ Difficulty Sleeping	□ Blurred Vision
□ Arm Pain	□ Memory Loss	□ Back Stiffness
□ Numb Fingers	□ Shoulder Pain	□ Neck Stiffness
□ Neck Pain	□ Fatigue	Other:
□ Tension	□ Chest Pain	□
□ Severe/Frequent Headaches	□ Numb Feet/Toes	□
□ Buzzing/Ringing in Ears	□ Jaw problems	□
□ Leg Pain	□ Difficulty Breathing	□
□ Lower Back Pain	□ Irritability	□

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and Goes

PATIENT TREATMENT CONSENT FORM

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.

I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Gillis Chiropractic.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

List of prices (subject to change):
Chiropractic Adjustment: $55.00, Examinations: $60.00/$130.00, Therapy: $35.00/each, X-rays: $35-$100 each

Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

_____ _____
Patient Name Date

_____ _____
Patient/Guardian Signature Date