Healthcore CLINIC

WELCOME TO OUR OFFICE

We would like to make your visits pleasant and successful… therefore, if you have any questions regarding treatments, financial arrangements, or scheduling of appointments, please feel free to ask. We are here to help!
There are several payment alternatives available. Please check the payment plan that applies to you listed below.

_____ **INSURANCE-** I am covered by an insurance policy and I am responsible for paying any co-payments, deductibles and noncovered services. Any portion not paid by my insurance company will be my responsibility

_____ **AUTO ACCIDENT, WORKER'S COMPENSATION, OR SLIP AND FALL-** (Other party responsible) This usually covers your medical bill at 100%. Please supply the front desk with the complete mailing address of the party responsible for the charges. For auto cases, please be aware that should your medical payment benefits become exhausted, you will be responsible for any unpaid charges. Also, in all cases, if we agree to wait for settlement, you will be responsible to make sure that this office does receive payment for services rendered at the time settlement is made. In the unlikely event that a problem arises with the settlement, you will agree to make arrangements for full payment to this office.

_____ **SELF PAY-** I will be paying daily or weekly on a cash basis.

_____ **NONE OF THE ABOVE-** If none of the above applies to you please ask for a consultation with one of the assistants before seeing the doctor.
If you have insurance, we will need to make a copy of your card and have you complete and sign an insurance form for our records.
Returned checks and balances over 30 days may be subjected to additional collection fees and interest charges of 1 ½% per Month.

I UNDERSTAND THAT ALL CHARGES NOT COVERED BY INSURANCE, REGARDLESS OF THE REASON, ARE MY FULL RESPONSIBILITY.

_____
(Print Name)

_____
(Signature)

_____
(Date)

180 N. Barrington Road, Streamwood, IL 60107
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NEW PATIENT DEMOGRAPHICS

Please print all responses.

Name _____

Address _____

_____

_____

Date of Birth: _____

Gender: M F

Social Security Number _____

Marital Status _____

Telephone Numbers OK to leave a message?

Home (___) _____ Y N

Cell (___) _____ Y N

Emergency Contact _____

Telephone (____) _____

Relationship _____

Financial Information

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐Personal Injury/Auto ☐ Other (Please explain) _____

Primary Insurance

Name _____

Relationship to insured: ☐Self ☐Spouse ☐Parent

Insured's Name: _____
(Other than self)

ID # _____

Group # _____

Date of birth of Policy Holder: _____

Secondary Insurance

Name _____

Relationship to insured: ☐Self ☐Spouse ☐ Parent

Insured's Name: _____
(Other than self)

ID# _____

Group # _____

Date of birth of Policy Holder _____

Employer

Status: ☐Full Time ☐Part Time ☐Retired ☐Unemployed

Name _____

Address _____

_____

Tel (___) _____ Fax (___) _____

School

Status: ☐Full Time ☐Part Time ☐Not a Student

How did you hear about our office?

_____

_____

_____

To the best of my knowledge the information contained in this form is true and accurate.

_____
(Print Name)

_____
(Signature)

_____
(Date)

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HEALTH HISTORY

Patient Name: _____ Today's Date _____

What is your reason for today's visit? _____

Check conditions you currently have or have had in the past

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL

- ☐ Bloating
- ☐ Bowel Change
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

SKIN

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars

MUSCLE/JOINT/BONE

- ☐ Arms
- ☐ Neck
- ☐ Back
- ☐ Hips
- ☐ Legs
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Knee
- ☐ Feet

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Discoloration of urine
- ☐ Lack of bladder control

MEN ONLY

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

WOMAN ONLY

- ☐ Breast Lump
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Vaginal Discharge
- ☐ Other _____
- ☐ Are you Pregnant? Yes/No

CONDITIONS

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Venereal Diseases

MEDICATIONS

List medications you are currently taking

_____ _____

_____ _____

ALLERGIES

_____

_____

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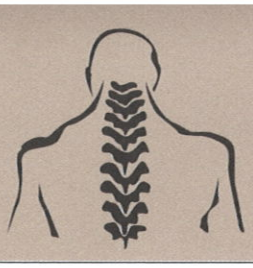

Family History

Relation	Age	State of Health	Age of death	Cause of death	Check if your blood relatives had any of the following:		
Father					√	Disease	Relationship to you
Mother						Arthritis, Gout	
Brothers						Asthma, Hay Fever	
						Cancer	
						Chemical Dependency	
						Diabetes	
Sisters						Heart Disease, Stroke	
						High Blood Pressure	
						Kidney Disorder	
						Tuberculosis	
						Other	

Hospitalization/Serious Illness/Injuries

Date	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complication

Occupational

Occupation:			
Check if your work exposes you to the following:			
	Stress		Hazardous Substances
	Heavy Lifting		Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

(Print Name)

_____ _____

(Signature) **(Date)**

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ASSIGNMENT OF BENEFITS

RELEASE OF INFORMATION

You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your treatment facility.

RIGHT TO RECEIVE PAYMENT

I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney, insurance company, or any other party who may become obligated to pay me draft containing my name to which you are legally entitled.

ASSIGNMENT OF RIGHT TO SUE

In the event any insurance company, attorney, or any other person obligated by contractual agreement to make payment to me for your service charges, refused to make such payment upon by demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, attorney, or person and authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

ATTORNEY DIRECTION

I hereby direct my attorney not to interfere with or claim by lien upon, by medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorneys to sign his name to these checks for the benefit of the medical provider herein

GUARANTEE OF PAYMENT

I understand that I am ultimately responsible for payment for this/these service(s) rendered and I agree to pay in full for all services within 30 days of receiving a bill from the above-mentioned medical provider.

_____

(Print Name)

_____ _____

(Signature) **(Date)**

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working or associated with or serving as back-up for the doctor of chiropractic named below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 judgement during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I see treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Consolidated Chiropractic Health Associates Inc. Notice of Privacy Practices.

_____
(Print Name)

_____ _____
(Signature) **(Date)**

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