CONFIDENTIAL PATIENT APPLICATION

Name: _____Gender: M F Birth Date _____/_____/_____

Home Address: _____ Cell Phone: _____

City, State, Zip: _____Home Phone: _____

Email Address: _____ Work Phone: _____

Social Security #_____-_____-_____ Marital Status S M D W How referred? _____

Occupation: _____ Employer Name:_____

Names of Children: _____Ages: _____

Spouse's Name: _____ Phone: _____ Email:_____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when:_____

When did this condition begin? _____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:_____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: Arm Leg Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: Work Sleep Hobbies Daily Routine Explain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Are you taking any MEDICATIONS? If yes, please list: _____

_____

_____

_____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____ When?_____

Reason for visits:_____

How did you respond? _____

Did your previous chiropractor take x-rays? ☐ Yes ☐ No

YOUR LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other:_____

What activities? Walking Running Jogging Weight Training Cycling Yoga Pilates Swimming

_____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

On a scale of 1-10, describe your stress level 1-None/ 10-Extreme for Occupational Stress_____ Personal _____

On a scale of Poor (P), Good (G), Excellent (E), describe your lifestyle. P G E

PAST SURGERIES, ACCIDENTS, PHYSICAL TRAUMAS

Please list all past **surgeries and dates**: _____

_____

_____

_____

Have you ever been in an **accident**? YES NO Work Related Auto Sports Other: _____

Nature of accident: _____ When? _____

_____

_____

_____

_____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Wellness Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Bence Chiropractic Wellness Center (BCWC) for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Bence Chiropractic Wellness Center, PLLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with BCWC, including those working at the clinic or office, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

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, disk 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. 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 treatment.

Signature_____ Date _____

(If under age 18 Parent/Guardian signature)

CONSENT TO X-RAY

I hereby grant Bence Chiropractic Wellness Center, PLLC permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature_____ Date _____
(If under age 18 Parent/Guardian signature)

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature_____ Date _____
(If under age 18 Parent/Guardian signature)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature_____ Date _____
(If under age 18 Parent/Guardian signature)

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date _____
(If under age 18 Parent/Guardian signature)

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. *By signing this form, you are giving us authorization to contact you with these reminders and information.*

_____ _____

Patient Signature: Date:

_____

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

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For Office Use Only:

Height: _____ft _____in Weight: _____lbs HR:_____bpm BP:_____/_____mmHG

Signed form received by: _____

Report of Findings: _____(time and date)