Kantner Chiropractic Application for Care

801 Brewfield Drive, Wapakoneta, OH 45895 • Phone: 419-738-4373 • Fax: 419-738-3780

Dr. Ronald Kantner, Dr. Michael Nagel

PATIENT INFORMATION

Name: _____

Nickname: _____

Date of Birth: _____

Address: _____

City:_____State:_____Zip_____

Please Check

❑ Male
❑ Female

❑ Right handed
❑ Left handed

❑ Married
❑ Single

Smoker? ❑ Current ❑ Past ❑Never

Social Security #: _____

Occupation: _____

Employer: _____

Work Duties: _____

Spouse/Partner: _____

Children's Name & Ages: _____

_____

CONTACT INFORMATION

Preferred Phone: _____

Work Phone: _____

E-mail: _____

Emergency Contact: _____

Emergency Contact #: _____

ACCIDENT

Is this condition due to an accident? ❑ Yes ❑ No

Type of accident: ❑ Auto ❑ Work ❑ Home

Date of Accident: _____

INSURANCE INFORMATION

Subscriber's Name: _____

Relationship To Patient: _____

Birth date: _____

HEALTH HISTORY

Reason for visit: describe **chief complaint** and any **additional** problems. Rate the symptoms on a scale of **1-10 (10 being the worst)**

1. _____ _____ (1-10)
2. _____ _____ (1-10)
3. _____ _____ (1-10)
4. _____ _____ (1-10)

When did the symptoms first appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unsure

Family members with similar symptoms: _____

Date of last Chiropractic visit: _____Dr.'s name: _____

Other Doctors you have seen for this symptom: _____

Past surgeries & dates: _____

List X-rays in past 2 years:_____

Medications you currently take:_____

Is there any chance you are pregnant? ❑ No ❑ Yes Due Date: _____

Whom may we thank for referring you? _____

I certify the above information is true and accurate to the best of my knowledge.

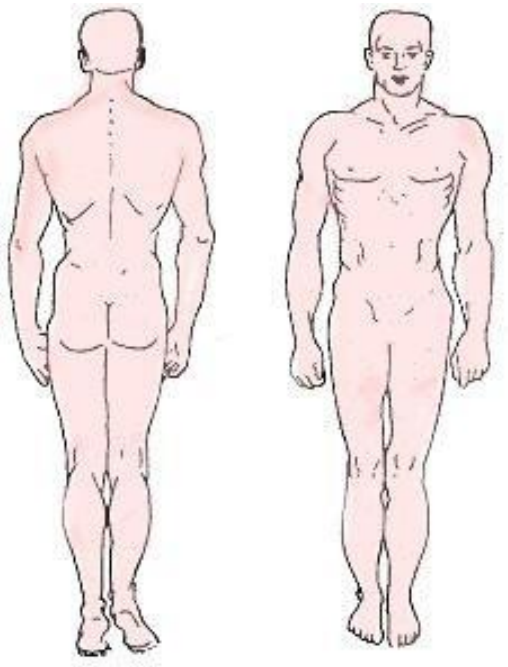
Signature: _____ **Date:** _____

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check:*

Condition, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Heart Problems	❑	❑
Ringing In Ears	❑	❑
Cough	❑	❑
Chest Pains	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin Conditions	❑	❑
Other	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank You for being Complete and Thorough

Family Health History

Please list ALL known diagnosed health conditions: (i.e. arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol)	**Relationship to you:** (i.e. mother, father, sister, brother, aunt, uncle, maternal & paternal grandparents)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

PRIVACY NOTICE
NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can gain access research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practical operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in this office.

You may file a complaint about privacy violations by contacting our Office Manager.

Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/ INTENT TO PAY DOCTOR

I hereby assign all medical benefits available for the services rendered by Kantner Chiropractic. I authorize direct payment of these services to the above office address.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

I understand that if my account is delinquent more than 60 days a formal collection process will begin and additional fees may be incurred.

I authorize my healthcare provider and/or any 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 using any telephone number, email address and/or mailing address provided. I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Signature: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you.

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Kantner Chiropractic (Dr. Ronald Kantner or Dr. Michael Nagel) I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only

To the best of my knowledge **I am/ am NOT** pregnant and **(give permission/don't give permission)** to x-ray me for diagnostic interpretation.

Missed Appointments

There is a possible Time of Service charge of $40.00 for all appointments that are not canceled 24 hours prior to scheduled visit.

Consent to Evaluate and Treat a Minor

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/minor to receive chiropractic care.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Phone: _____
Children: _____ Phone: _____
Others: _____ Phone: _____

Print Name: _____

Signature_____ **Date: _____**

KANTNER CHIROPRACTIC