Belle Haven Family Chiropractic

NEW PATIENT INFORMATION

Patient First Name:_____ M.I.:_____ Last Name: _____

I would prefer to be called: _____ SS #: _____ - _____-_____

Sex: □ M □ F Birth/date: _____/_____/_____ Height: __'__ Weight: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Home #: (____) _____-_____

Cell phone: (____) _____-_____ Okay to call? Yes or No Okay to text? Yes or No

Work #: (____) _____-_____ ext. # _____ OK to call ? Yes or No

Email Address: _____

Occupation: _____ Employer: _____

Business Address: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Name of Spouse: _____ Date of birth: _____/_____/_____ Phone #: (____) _____-_____

Children: _____ Date of your last Physical Examination: _____/_____/_____

In the event of an emergency, whom should we notify? _____ Phone #: (_____) _____-_____

Relationship to above- named patient: _____

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NEW PATIENT HEALTH QUESTIONNAIRE

Please describe complaints below: (i.e. low back, shoulder, neck)

1. Involving head/neck: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
The pain is aggravated by: _____

The pain is relieved by: _____

2. Involving Mid Back/Shoulders/Arms & hands: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

3. Involving Lower Back/Hips/Legs & Feet's: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

Symptoms have persisted for: ❒ _____ Hours ❒ _____ Days ❒ _____ Weeks ❒ _____ Months ❒ _____ Years
Are your symptoms/condition: ❒ Improving ❒ unchanged ❒ getting worse
Have you seen another physician for these conditions? _____
If Yes, Physician name & tests performed: _____
Have you had x-rays or other tests performed for this condition? No Yes What / When
_____

Indicate your ability to perform the following activities: **U=Unable, P=Painful, D=Difficult, L=Limited, N=Normal**

_____ Coughing or sneezing	_____ Getting in or out of a car	_____ Bending forward to brush teeth
_____ Turning over in bed	_____ Walking short distances	_____ Prolonged standing
_____ Sitting at a table	_____ Lying on back	_____ Lifting up to 15 lbs
_____ Getting dressed	_____ Sleeping	_____ Pushing/Pulling
_____ Driving a car	_____ Reaching	_____ Sexual activity

MEDICAL HISTORY:
What MEDICATION are you presently taking and for what condition? _____
Have you ever been diagnosed with Cancer? ❒ No ❒ Yes Describe: _____

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

❒ Buzzing or ringing in ears	❒ Blurring vision	❒ Rectal bleeding
❒ Loss of bowel or bladder function	❒ Loss of sleep	❒ Dizziness
❒ Stomach difficulty/abdominal px	❒ History of Stroke	❒ Chest pain
❒ Confusion/loss of Memory	❒ Constipation	❒ Depression
❒ Frequent urination or painful	❒ Cancer	❒ Diarrhea
❒ Difficulty swallowing	❒ Allergies	❒ Asthma
❒ Unexplained weight loss/gain	❒ Current Fever	❒ Aids/HIV
❒ Heart Diseases	❒ Fainting	❒ Arthritis
❒ Numbness/Tingling	❒ Headaches: Area of head: _____	

How often: ❒ _____ times/day ❒ _____ times/week ❒ _____ times/month

Do you have a pacemaker? ❒ Yes ❒ No Do you have any metal implants ❒ Yes ❒ No

Please list any serious illness or medical conditions you have had and associated treatment**:**

_____

WORK HISTORY:

How many hours do you normally work in a week? _____ Are you currently not working? ❒ Yes ❒ No

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8 hours
Stand:	1	2	3	4	5	6	7	8 hours
Walk	1	2	3	4	5	6	7	8 hours

Does your job require physical labor? If yes, please describe: _____

SOCIAL HISTORY:

Do you smoke? ❒ No ❒ Yes If yes, Packs per day _____

Do you drink caffeine? _____ ❒ No ❒ Yes: if yes, cups per day _____

Do you consume alcohol? ❒ No ❒ Yes; if yes, drinks per week _____

Exercise: ❒ Light ❒ Moderate ❒ Heavy/Intense ❒ None

FAMILY HISTORY: Please list any family history of heart disease, cancer, diabetes or other serious illness:

Father: _____ Mother: _____ Siblings: _____

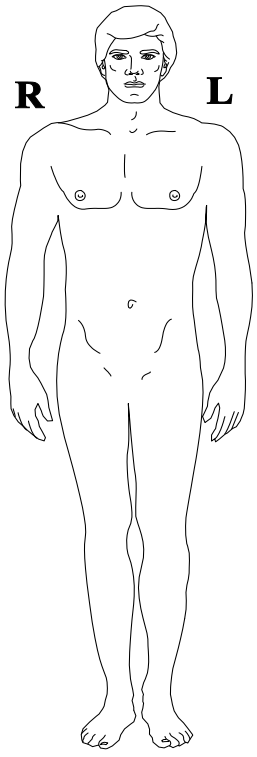
Woman Only: Are you pregnant? ❒ Yes ❒ No Date of last menstrual cycle: _____

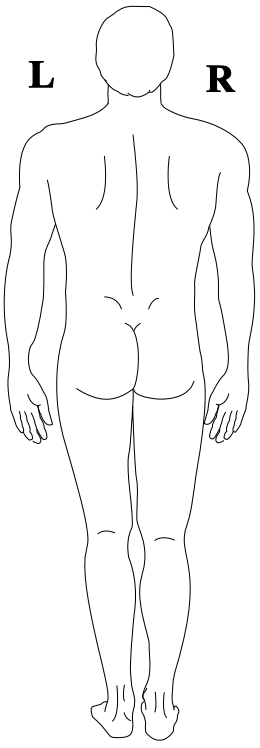
Men Only: Last Prostate exam: _____ results: _____

PAIN DIAGRAM

Use these symbols to describe the type of pain or sensations you are feeling:

***	**Stiffness**
>>>	**Aching pain**
///	**Stabbing or Sharp**
XXX	**Burning pain**
===	**Numbness**
ooo	**Pins and Needles**





Patient's Name: _____ Patient's Signature: _____ Date: ___/___ /____

(Or guardian if child)

BELLE HAVEN FAMILY CHIROPRACTIC

OFFICE POLICY

APPOINTMENT POLICY: To minimize waiting and to facilitate incorporating these appointments into your daily routine, we ask that you schedule appointments for the week. Please note that in order to achieve successful treatment results it is the frequency of visits that is important. If you are unable to keep an appointment for any reason, we require that you call to reschedule at least 24 hours in advance. **There is a $50 fee for same day cancellations.**

FINANCIAL AND INSURANCE POLICY: It is our policy that all services are charged directly to you and that you are personally responsible for all payments, unless your doctor is under contract with your insurance company (Managed Care Plans) or you have been involved in a Workman's Compensation Injury.

MANAGED CARE PLANS: Under a Managed Care Plan you are required to make a co-payment for each visit. Typically, your policy will cover a certain number of visits per year per condition. You are required to pay for any services that are not covered. You are not required to pay for covered services that are not paid 100%. You are also required to pay for any services received beyond your policy limits and your plan deductible when applicable.

WORKMAN'S COMPENSATION: Workman's Compensation Insurance covers 100% of all services provided for treatment for work-related injuries. You must have authorization from your employer or your employer's insurance carrier.

COMMERCIAL INSURANCE: If you have Commercial insurance you will have a copayment percentage and possibly a deductible. You will be responsible for any portion of your bill not paid by your insurance company.

PERSONAL INJURY CLAIMS: Car accident insurance will usually cover 100% of all services they feel are medically necessary. We cannot, however, control what they consider to be medically necessary. Some insurance companies will make payments directly to the doctor, which will allow you to receive care without making payments each visit. If you have an attorney, you must both sign an "Attorney's Lien" in order for us to wait to receive the balance of payment at settlement. If we do not maintain contact with you or your attorney, or if you discontinue care without recommendation by your doctor, the bill for services rendered is due immediately and payment in full will be expected.

NON-INSURANCE: Many of our patients do not have insurance that covers chiropractic care. We participate with a reduced fee for service program, Preferred Chiropractic Doctors ("PCD"), which makes care affordable in these cases.

Should you discontinue care for any reason other than discharge from the doctor; any and all balances will become immediately due and payable in full, regardless of any claims submitted. All accounts not paid within 30 days will turned over to an outside agency for collection and all costs of collection, including agency fees, legal expenses and court costs will be the responsibility of the patient. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 6% per month. These additional fees will be applied to the unpaid balance at the 1st date of the following month.

We will attempt to verify your insurance coverage as soon as possible, but we will not guarantee that an insurance company will pay for a claim as verified. We require that you also verify your individual coverage.

I understand these office policies and agree to abide by the same:

Printed name: _____ Signature: _____ Date: ____/_____/_____

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provided information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

· Protected health information may be for disclosed or used treatment, payment, or health care operation
· The Practice has a Notice of Privacy Practices and that the patient had the opportunity to review this Notice
· The Practice reserves the right to change the Notice of Privacy Practices
· The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
· The patient maybe revoke this Consent in writing at any time and all future disclosures will then cease
· The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name- Patient or Representative

_____ ___/____/____
Signature **Date**

Relationship to Patient
(If other than patient): _____

Witness: _____
Printed Name- Practice Representative

_____ __/_____/____
Signature **Date**