APPLICATION FOR CARE AT CARDINAL CHIROPRACTIC & PHYSICAL MEDICINE

Date:_____

PATIENT DEMOGRAPHICS

Name:_____ Birth Date: ___/___/___ Age:_____ Sex: M / F

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Social Security #:_____ Do you have Medical Insurance? ☐ Yes ☐ No

Employer Name:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer:_____

Number of Children and Ages:_____

Primary Care Physician and Phone Number:_____

Emergency Contact Name:_____ Phone Number:_____

Emergency Contact Relationship:_____

HISTORY OF COMPLAINT

Please explain the condition(s) that brought you to the office:_____

_____

_____

When did the problem(s) begin?_____

When is the problem(s) at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week

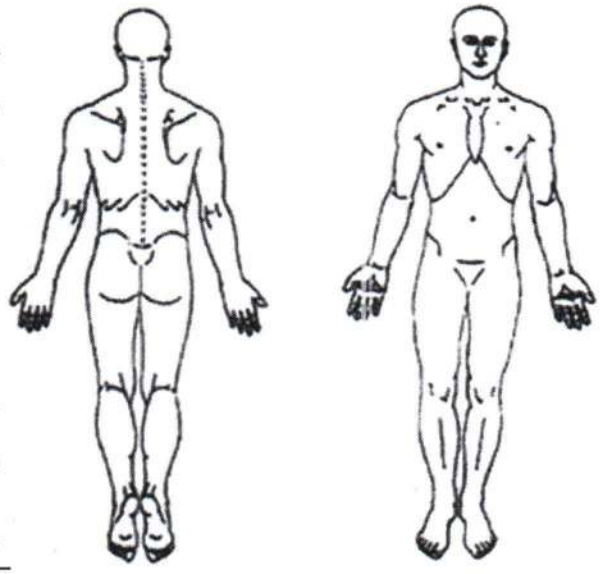
How did the injury happen:_____

Have you been treated for this problem in the past? ☐ Yes ☐ No

If yes, when?_____ By whom?_____

How long were you under care?_____

What were the results?_____



*__PLEASE MARK__ the areas on the diagram with the following **letters** to describe your symptoms: **R**- Radiating **B**- Burning **D**- Dull **A**- Aching **T**- Tingling **N**- Numbness **S**- Sharp/Stabbing **ST**- Stiffness

What relieves your symptoms?_____

_____

What makes them feel worse?_____

_____

What is your pain on a scale from 1 – 10 (10 being the worst pain possible):_____

Is your problem(s) the result of **ANY** type of accident? ☐ Yes ☐ No

If yes, Please explain: _____

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No If yes how many times? _____

When was the last episode? _____ How did the injury initially happen? _____

_____

Other forms of treatment tried? ☐ Yes ☐ No If yes, what type of treatment? _____

Who provided it? _____ How long ago? _____

What were the results? _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, C for ***Currently*** have and **N** for ***Never*** have had:

_____Broken Bone _____Dislocations _____Tumors _____Rheumatoid Arthritis _____Fracture _____Disability

_____Cancer _____Heart Attack _____Osteoarthritis _____Diabetes _____Cerebral Vascular _____Other: _____

_____

PLEASE identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your **present** problem:

Injuries: _____

How long ago? _____ Type of care received: _____

By whom? _____ What were the results? _____

Surgeries: _____

How long ago? _____ Type of care received? _____

By whom? _____ What were the results? _____

Childhood Diseases: _____

How long ago? _____ Type of care received? _____

By whom? _____ What were the results? _____

Adult Diseases: _____

How long ago? _____ Type of care received: _____

By whom? _____ What were the results? _____

SOCIAL HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes ☐ Vaporizer/Electronic Cigarette

How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcohol Consumption: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

How many drinks consumed in one setting?_____

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Type of Drug:_____

Hobbies- Recreational Activities- Exercise Routine:_____

_____

How does your present problem affect your routine?_____

_____

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes whom? ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother(s) ☐ Sister(s) ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Are there any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No If yes, please list conditions: _____

_____

_____

List Prescription and Non-Prescription drugs you take including Supplements:

_____

_____

_____

_____

_____

Please list all allergies you have: (Drug, Food, Seasonal, Etc)

_____

_____

_____

_____

_____

Please mark " **P** " for in the ***past*** and " **C** " for ***Currently have***

_____Headache	_____ Pregnant	_____ Dizziness	_____ Prostate Problems	_____ Ulcers
_____ Neck Pain	_____ Frequent Colds/Flu	_____ Loss of Balance	_____Impotence/Sexual Dysfun.	_____ Heartburn
_____ Jaw Pain, TMJ	_____ Fainting	_____ Heart Problems	_____Convulsions/Epilepsy	_____ Tremors
_____ Shoulder Pain	_____ Double Vision	_____ Colon Trouble	_____ Digestive Problems	_____ Chest Pain
_____ Blurred Vision	_____ Upper Back Pain	_____ Mid Back Pain	_____ High Blood Pressure	_____ Low Back Pain
_____ Ringing in Ears	_____ Difficulty Breathing	_____ Hearing Loss	_____ Low Blood Pressure	_____ Hip Pain
_____ Back Curvature	_____ Foot/Knee Problem	_____Sinus Problem	_____Diarrhea/Constipation	_____ Asthma
_____ Depression	_____ Menstrual Problems	_____Lung Problems	_____ Menopausal Problems	_____ PMS
_____ Kidney Trouble	_____ Skin Problems	_____Bed Wetting	_____ Pain w/Cough/Sneeze	_____Irritable
_____ Mood Changes	_____ Learning Disability	_____ ADD/ADHD	_____ Swollen/Painful Joints	_____ Scoliosis
_____ Eating Disorder	_____ Gall Bladder Trouble	_____ Liver Trouble	_____ Numb/Tingling (arms, hands, fingers)	
_____ Hepatitis (A,B,C,)	_____ Trouble Sleeping	_____ Allergies	_____ Numb/Tingling (legs, feet, toes)	

QUESTIONS OR COMMENTS FOR DOCTOR:

_____

_____

_____

_____

_____
Patient Signature or Authorized Person's Signature

_____
Date Completed

_____
Doctor Signature

_____
Date Reviewed

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that Chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per five million, have been associated with Chiropractic adjustments.

Treatment objectives as well as the risks associated with Chiropractic adjustments and, all other procedures provided at Cardinal Physical Medicine have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays and Imaging Services:

FEMALES ONLY: *Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on _____/_____/_____ (MM-DD-YYYY)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

Patient Name:_____ Date of Birth:_____

CARDINAL CHIROPRACTIC & PHYSICAL MEDICINE

1404 Triad Center Drive
Saint Peters, MO 63376
Phone: 636-352-0380
Fax: 636-352-2343

Richard Blalock, D.C.

OFFICE POLICIES AND PROCEDURES FOR OUR PATIENTS

Office Hours for Dr. Blalock:

Monday:	8:00am – 6:30pm
Wednesday:	8:00 am – 6:00pm
Thursday:	8:00am – 6:00pm
Friday:	CLOSED
Saturday:	CLOSED
Sunday:	CLOSED

**Office hours are subject to change and are listed with the exception of holiday closures.*
**Lunch is taken on Monday, Wednesday, and Thursday for 1 hour per day.*
NO APPOINTMENTS WILL BE ADDRESSED AFTER HOURS.

APPOINTMENTS

Cardinal Chiropractic & Physical Medicine is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments well in advance for follow-up care. To ensure quality care, our physicians do not treat patients they have not seen and telephone consultations are not available.

In order to provide you with the best care, it is requested that you attend all scheduled appointments per your physician provided treatment plan. Our office does ask that you are on time for your appointments. If you are going to be late, please call the office to let them know. Also be aware that we cannot always accommodate late appointment arrivals therefore we may have to reschedule your appointment. Appointment times are limited and therefore we require a 24 hour notice for all cancellations.

If appointments are not cancelled within 24 hours of the scheduled time, a ***no show fee*** may be added to your account.
No show fees are as follows:
Chiropractic: $45

Patient Initials: _____

INSURANCE BILLING

As a courtesy to our patients, Cardinal Chiropractic & Physical Medicine is happy to file insurance claims on your behalf. We accept most major insurance carriers. Please ask an office representative for further information. It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payments. The patient is ultimately responsible for ALL outstanding balances.

CO-PAYMENT AND DEDUCTIBLES

Patients are responsible for co-payments ***at time of service***. You will be billed for any applicable deductibles or co-insurance amounts and/or fees for services not covered by your insurance (as stated in your insurance contract) by our billing department. If we are unable to verify insurance coverage prior to your scheduled appointment, you will be responsible for fees associated with the office visit ***at the time of service***.

PAYMENTS

Cardinal Chiropractic & Physical Medicine accepts cash, checks, and all major credit cards. We will make all reasonable attempts to collect outstanding patient balances. We reserve and will exercise the right to add a $25.00 finance charge to accounts past due at 30 days, 60 days, and 90 days of the invoice date. Any account 90 days past due will be reported to a collections agency. All expenses incurred from the collections process will be the patient's responsibility, as permitted by law.

Bounced Check Policy

If your check bounces you are responsible for the amount of the check, a $35.00 fee, and all expenses incurred in the collection process to recover the original amount.

FORMS/LETTERS

We understand that at times various forms or letters may be required to assist you with your healthcare needs. Cardinal Physical Medicine will be happy to complete forms and write medical letters as necessary upon request. However, because this can be time consuming and not covered under your insurance, fees for this service will apply. While these charges may vary, they generally range from $25-$50 per form. Costs will be discussed ahead of time and pre-payment is required. Please allow 10-14 business days for completion of requested forms/letters.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to release of these materials. All patients can request a copy of their records at any time for a normal fee. Payment is required prior to records being processed. Please allow 15-30 days to complete requests for records.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date