MONTROSE
FAMILY CHIROPRACTIC

Insurance Information Form

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

Patient name: _____ **Date of birth:** _____
Last First Middle initial month/day/year

Address: _____
Street Address po box city state zip code

Phone: Home: _____ Cell: _____

Social Security Number: _____ **Email:** _____

Sex: Male Female **Marital Status:** Single Married other Spouse Name: _____

Employers name: _____ **Work Phone Number:** _____

Emergency contact: _____ **Phone Number:** _____

Do you have health insurance? **Yes** (fill out next section) **No** (skip next section)

_____ _____ _____ _____ _____
Primary Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Group Number:** _____

_____ _____ _____ _____ _____
Secondary Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Group Number:** _____

I authorize the release of any medical or other information to Montrose Family Chiropractic as necessary to process this claim. I also request payment of medical benefits from either a government or non-government source to Montrose Family Chiropractic. I authorize Montrose Family Chiropractic to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, and I understand that I will be charged 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00, on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged for $40.00 for each returned check. While Montrose Family Chiropractic will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

MONTROSE
FAMILY CHIROPRACTIC

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

Patient Name: _____ **Date:** _____

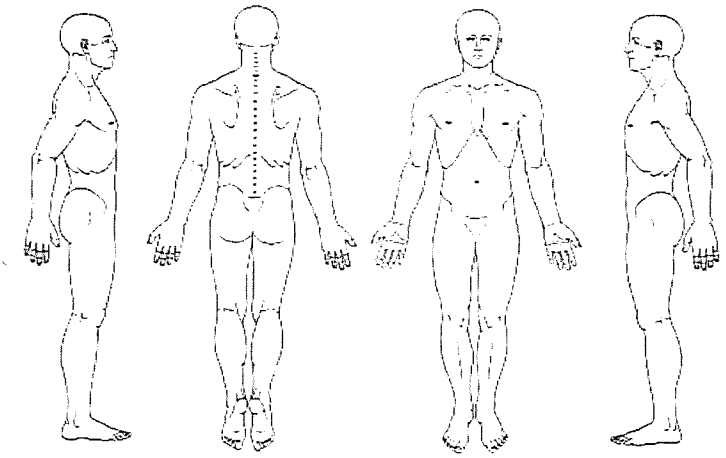
1. **Describe your symptoms:** _____

_____

   a. **When did it start?** _____
   b. **How did your symptoms begin?** _____
   c. **If you're injured, where did the injury occur?** Home work auto other: _____

2. **How often do you experience your symptoms:**
   a. Constantly (79-100% of the day)
   b. Frequently (51-75% of the day)
   c. Occasionally (26-50% of the day)
   d. Intermittently (0-25% of the day)
3. **What describes the nature of your symptoms?**
   a. Sharp
   b. Shooting
   c. Dull ache
   d. Burning
   e. Numb
   f. Tingling
4. **How are your symptoms changing?**
   a. Getting better
   b. Not changing
   c. Getting worse

Indicate where you have pain or other symptoms on the diagram:



5. **During the past four weeks:**
   a. **Indicate the average intensity of your symptoms:**
   (none)- 1 2 3 4 5 6 7 8 9 10-(unbearable)
   b. **How much has the pain interfered with your normal work (including both work outside of home and housework)**

   Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**

6. **During the past four weeks, how much of the time has your condition interfered with your social activities?**

   All the time **Most of the time** **Some of the time** **A little bit of the time** **None of the time**

7. **In general, how would you say your overall health is right now?**

   Excellent **Very good** **Good** **Fair** **Poor**

8. **Who have you seen for your symptoms?**
   No one **Medical Doctor** **Another Chiropractor** **Physical Therapist** **Other:** _____
   a. **What treatment did you receive and when?** _____
   b. **What test have you had for your symptoms and when were they performed?** _____
9. **Have you had similar symptoms in the past?** **Yes** **No**
   a. **If your have received treatment in the past for the same or similar symptoms, who did you see?**

   This office **Medical Doctor** **Another Chiropractor** **Physical Therapist** **Other:** _____

MONTROSE
FAMILY CHIROPRACTIC

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

10. The problem is worse with:

Coughing	Sneezing	Straining	Sleeping
Lifting	Rest	Activity	Sitting
Standing	Weather changes		Other: _____

11. The problem is better with:

Medication	Rest	Activity	Stretching
Adjustments	Ice	Heat	Other: _____

12. What household, social, recreational, or work activities are now difficult or impossible to do because of your problem?

_____

_____

_____

_____

13. Please circle below any symptoms or conditions you are currently experiencing or have in the past:

Allergy	Anemia	Ankle pain	Asthma	Arthritis
Bursitis	Back pain	Chest pain	Diabetes	Dizziness
Depression	Fatigue	Menstrual cramps	Flat Feet	Headaches
Heart Attack	Ulcers	High Blood Pressure	Spinal Curvature	Hot Flashes
Knee Pain	Nervousness	Eye pain	Osteoporosis	Low Blood Pressure
Cancer	Colitis	Fainting	Kidney Pain	Stroke
Abdominal Pain	Sinus Trouble	Shoulder Pain	Thyroid Disease	Painful Urination
Rheumatic Fever	Numbness in Hands		Numbness in Feet	Other: _____

14. Do you have any previous fractures, dislocations, spinal injuries, surgeries, serious injuries, or illnesses not listed above? **No** **Yes, Please List:** _____

_____

15. Do you use tobacco? **No** **Yes, how much?** _____
Do you use alcohol? **No** **Yes, how much?** _____
Do you use caffeine? **No** **Yes, how much?** _____

16. Do you take any medications or vitamins? **No** **Yes, please list:** _____

_____

17. Do you exercise regularly: **No** **Yes, how often and how long?** _____

18. What is your occupation?

Professional/executive	**Laborer**	**Retired**
White collar/Secretarial	**Homemaker**	**Tradesperson**
FT Student	**Other:** _____	

19. Were you referred? **No**
Medical doctor, Name _____
Another patient, Name _____
Other _____

Patient Signature: _____ **Date:** _____