New Patient Application

Welcome to our practice! Please thoroughly complete all questions.

Patient Name: ____

Date:________________

Address:____________________________ City:_________________State:___Zip________

Phone: Cell______________Work_____________ Social Security Number:______________

Date of Birth: ___/___/_____ Age:_____ Email:____________________________________

Marital Status: Married/Divorced/Single

How did you hear about us/who may we thank for referring you?_________________________

Occupation:___________________ Employer:_________________ Phone:______________

Employer Address:____

Spouse's Name:______________________ Spouse's Employer:_________________________

Children's Names & Ages:____

Hobbies & Interests:____

____

Prior Doctor of Chiropractic:____________________ Office Location:___________________

Last time you were checked by your prior Doctor of Chiropractic:_________________________

General Practitioner:_____________________ Office Location:________________________

Reasons for consulting our office:

1.____

2.____

3.____

Have you had the same or similar problem before? YES/NO

Have you had any X-rays, MRI, CT Scan for your area of complaint? YES/NO Date Taken:________

Is this a result of an auto-accident or work injury? YES/NO

If yes, when?____

List any other doctors that have treated this problem?___________________________________

Do you have family members with similar problems?______________________________________

Surgeries you have had:____

____

Medications you currently take:____

____

Supplements you currently take:____

____

What daily rituals for spinal health do you presently practice?______________________________

____

What daily rituals for general health & wellness do you presently practice?___________________

____

Family Medical History: Please list all known medical problems in your *immediate* family.
(Specify M=Mother F=Father B=Brother S=Sister GM=Grandmother GF=Grandfather)

____

____

____

____

____

____

What have you heard about Chiropractic?____
Do you know what a subluxation is? YES/NO

Any other concerns please describe here:

____

____

____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:________________________________Date:____________

Past Medical History-Please check all that apply

Condition	Yes	No
Adrenal Dysfunction	❑ Yes	❑No
Alzheimer	❑ Yes	❑No
Anxiety Disorder	❑ Yes	❑No
Arteriovenous Malformation	❑ Yes	❑No
Arthritis	❑ Yes	❑No
Asthma	❑ Yes	❑No
Autoimmune Disease	❑ Yes	❑No
Bipolar Disorder	❑ Yes	❑No
Bleeding Disorder	❑ Yes	❑No
Claudication	❑ Yes	❑No
Congenital Heart Defects	❑ Yes	❑No
Coronary Heart Disease	❑ Yes	❑No
COPD	❑ Yes	❑No
Cystic Fibrosis	❑ Yes	❑No
Depression	❑ Yes	❑No
Diabetes	❑ Yes	❑No
Eclampsia or Preeclampsia	❑ Yes	❑No
Endocarditis	❑ Yes	❑No
Endometriosis	❑ Yes	❑No
End Stage Renal Disease	❑ Yes	❑No
Fibromyalgia	❑ Yes	❑No
GERD	❑ Yes	❑No
Glaucoma	❑ Yes	❑No
Heart or Valve Defects	❑ Yes	❑No
Hepatitis	❑ Yes	❑No
HIV/AIDS	❑ Yes	❑No
Hypertension	❑ Yes	❑No
Hyperthyroidism	❑ Yes	❑No
Hypothyroidism	❑ Yes	❑No
Inflammatory Bowel Disease	❑ Yes	❑No
Malignancy *If yes describe below*		
Muscular Dystrophy	❑ Yes	❑No
Myocardial Infarction (Heart Attack)	❑ Yes	❑No
Obstructive Sleep Apnea	❑ Yes	❑No
Osteoporosis	❑ Yes	❑No
Peripheral Artery Disease	❑ Yes	❑No
Recurrent Infections	❑ Yes	❑No
Restless Leg Syndrome	❑ Yes	❑No
Schizophrenia	❑ Yes	❑No
Scleroderma	❑ Yes	❑No
Seizure Disorder	❑ Yes	❑No
Vaculitis	❑ Yes	❑No
Visual Defects	❑ Yes	❑No

Review of Systems In the last 6 months, have you experienced any of the following symptoms?

Constitutional

Symptom	Yes	No
Weight loss of gain	❑ Yes	❑No
Appetite changes	❑ Yes	❑No
Fatigue	❑ Yes	❑No
Fever	❑ Yes	❑No

Eyes

Symptom	Yes	No
Eye pain or drainage	❑ Yes	❑No
Visual Changes	❑ Yes	❑No
Dry, irritated eyes	❑ Yes	❑No

ENT/Mouth

Symptom	Yes	No
Ear pain or drainage	❑ Yes	❑No
Frequent sinus infections	❑ Yes	❑No
Hearing changes or loss	❑ Yes	❑No
Nosebleeds	❑ Yes	❑No
Dizziness	❑ Yes	❑No

Respiratory

Genitourinary

Symptom	Yes	No
Blood in your urine	❑ Yes	❑No
Menstrual changes	❑ Yes	❑No
Urinating that is painful or difficult	❑ Yes	❑No
Erection Problems	❑ Yes	❑No
Vaginal discharge or bleeding	❑ Yes	❑No

Musculoskeletal

Symptom	Yes	No
Broken Bones	❑ Yes	❑No
Joint pain or swelling	❑ Yes	❑No
Muscle aches	❑ Yes	❑No
Muscle weakness	❑ Yes	❑No
Back pain	❑ Yes	❑No

Neurological

Symptom	Yes	No
Seizures	❑ Yes	❑No
Coughing or choking with swallowing	❑ Yes	❑No
Extremity pain or burning sensation	❑ Yes	❑No
Numbness or tingling	❑ Yes	❑No

Respiratory

- Blood in your sputum ☐ Yes ☐No
- Chest Tightness ☐ Yes ☐No
- Cough lasting > 1month, productive or not ☐ Yes ☐No
- Shortness of breath ☐ Yes ☐No
- Wheezing ☐ Yes ☐No
- Chest pain with inhalation ☐ Yes ☐No

Cardiovascular

- Chest pain or heaviness ☐ Yes ☐No
- Palpitations ☐ Yes ☐No
- Fainting or near fainting spells ☐ Yes ☐No
- Swelling of feet of legs ☐ Yes ☐No
- Shortness of breath while lying flat ☐ Yes ☐No

Gastrointestinal

- Abdominal pain ☐ Yes ☐No
- Blood in your stool ☐ Yes ☐No
- Constipation ☐ Yes ☐No
- Diarrhea or Food Intolerance ☐ Yes ☐No
- Heartburn or Indigestion ☐ Yes ☐No
- Vomiting or nausea lasting for >1 day ☐ Yes ☐No
- Swallowing difficulty ☐ Yes ☐No

Psych

- Anxiety without clear explanation ☐ Yes ☐No
- Sadness lasting for days or weeks ☐ Yes ☐No
- Hearing voices ☐ Yes ☐No
- Thoughts of hurting yourself ☐ Yes ☐No
- Thoughts of hurting others ☐ Yes ☐No
- Fear of people places or things ☐ Yes ☐No

- Difficulty falling asleep or staying asleep ☐ Yes☐No

Endocrinology

- Hair loss ☐ Yes ☐No
- Frequent urination ☐ Yes ☐No
- Increased thirst ☐ Yes ☐No
- Heat or cold intolerance ☐ Yes ☐No

Heme/Lymph

- Bleeding from gums or nose ☐ Yes ☐No
- Unexplained bruising ☐ Yes ☐No
- Night sweats ☐ Yes ☐No
- Swollen painful lymph nodes ☐ Yes ☐No

Allergy/Immune

- Watery eyes ☐ Yes ☐No
- Runny nose ☐ Yes ☐No
- Food intolerance ☐ Yes ☐No
- Frequent skin sores ☐ Yes ☐No

Informed Consent to Chiropractic Treatment

Pickaway Chiropractic Center

778 North Court Street
Circleville, OH 43113

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the doctor the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:____ Date:___________

Signature of Parent/Guardian:________________________________ Date:__________

Doctors Signature:____ Date:___________

Notice of Financial Policy

Please carefully review the following policies regarding our financial practices pertaining to the collection of payment for the services provided at our office. Although we make every attempt to provide you with accurate information regarding your insurance benefits and coverage for all our services, we CAN NOT GUARANTEE your benefits will provide coverage for all of our services. **You insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize as health care providers, our relationship is with you and not your insurance company.** We ask that you also become familiar with your insurance policy by calling the Member Services phone number located on your insurance card or by logging in to your insurance company's website.

_______**MEDICARE:** Medicare provides chiropractic coverage for SPINAL ADJUSTMENTS ONLY. X-rays are not covered and will be a separate charge. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN). This form will explain which services Medicare may not cover and that you may be responsible for those charges.
ABN (Advanced Beneficiary Notice) Signed Yes ☐ No ☐

_______**MEDICAID:** We accept CARESOURCE and Medicaid card.. ODJS allows 15 chiropractic treatments per calendar year. Payment for any additional treatment will be the patient's responsibility.

_______**WORKER'S COMPENSATION:** We are a certified Ohio Worker's Compensation provider. Only active, allowed claims are eligible for treatment authorization requests. ALL TREATMENT MUST BE PRE-APPROVED. We require a secondary insurance in the event treatment is not authorized through Worker's Compensation. If you have no other insurance we will make every effort to arrange a comfortable payment schedule.

_______**AUTO ACCIDENTS/PERSONAL INJURY:** If you have been involved in an auto accident we will bill treatment for your injuries to YOUR AUTO INSURANCE. If you have comprehensive coverage (not just liability) you have "medpay" coverage. We will need to verify how much medpay coverage is available. If you were not the at-fault party your insurance company will recover any money paid from the at-fault party's insurance company. We will honor a LETTER OF PROTECTION from you attorney until 6 MONTHS AFTER THE LAST DATE OF TREATMENT. If we have not received payment after 6 months we will bill your auto insurance medpay. If you do not have medpay benefits we will bill your private health insurance or make a comfortable payment schedule.

_______**GENERAL HEALTH INSURANCE:** We are IN networks with the following major health insurance providers: Anthem BC/BS. Medical Mutual of Ohio, Aetna, Cigna, United Health Care. Also, please be aware of any deductibles and co-insurance that you may owe. Chiropractic services are typically reimbursed as a SPECIALIST or PHYSICAL THERAPY. Therefore, your co-pay may only apply to the initial office visit. Co-insurance and deductibles are calculated by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement, payable upon receipt.

_______**NO COVERAGE/SELF PAY:** We do not have alternative payment options if you do not have insurance that provides chiropractic benefits or if you have no insurance at all. We will customize a cash payment plan based on your individual treatment plans. Pre-pay, Monthly, or Pay as you Go are available based on your needs and frequency of care.

Massage Therapy Services, Spinal Supports, Pillows, Retail Goods, and all other non-physician provided services are NOT BILLED TO YOUR INSURANCE and payment is required at the time of service/purchase

Please remember your overall health needs are our NUMBER ONE priority here. We will not turn you away because you are underinsured or uninsured. We understand financial strains and will be respectful of your decisions to alter you recommended treatment plans to accommodate your payment responsibilities.

By signing below I acknowledge that I have read and understand the Financial Policies of Pickaway Chiropractic Center and that I am responsible for arranging payment of all services provided to me at this office.

Patient Signature (or Parent of Minor)_______________________________________Date _____________

Text Appointment Reminder

I would like to receive text reminders for my upcoming appointments with Pickaway Chiropractic Center.

Phone Number:____

Name:____

Date:____

Signature:____