____
Chart Number

____/____/______
Date

13708 MADISON AVENUE• LAKEWOOD, OHIO 44107 • 216,221.2008• FAX 216.221.6446• www.gentnerchiro.com

Confidential Patient Information

Last Name ______________ First Name ______________ Mi. Initial ______

Address ______________ City ______________ State ______ Zip ______

Email ______________ Home Phone (______)_____-______ Cell Phone (______)_____-______

D.O.B (MM/DD/YYYY) ______/_____/________ Male / Female

Social Security Number ________-______-_________ Occupation ______________ Employer ______________

Emergency Contact Name ______________ Relationship ______________ Phone (______)_____-_________

Ethnicity:

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Declined

Race:

___ American Indian/Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Pacific Islander
___White
___ Other
___ Declined

Preferred Language:

___ English
___ Spanish
Other: _____________

Insurance Information

Insurance Company ______________ ID Number ______________ Group Number ______________

Policy Holder Name ______________ Policy Holder Employer ______________ Policy Holder D.O.B. (MM/DD/YYYY) _______/_______/__________

Assignment of Benefits and Release of Medical and Plan Documents

I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign to Gentner Chiropractic Center all medical benefits and/or insurance reimbursement for services rendered. I understand that I am responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including, but not limited to, my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

______________________________________ ______________________

Signature of Patient or Parent/Guardian Date

____
Name

_____/_____/_______
Date

Has your address or insurance changed? **Y / N**

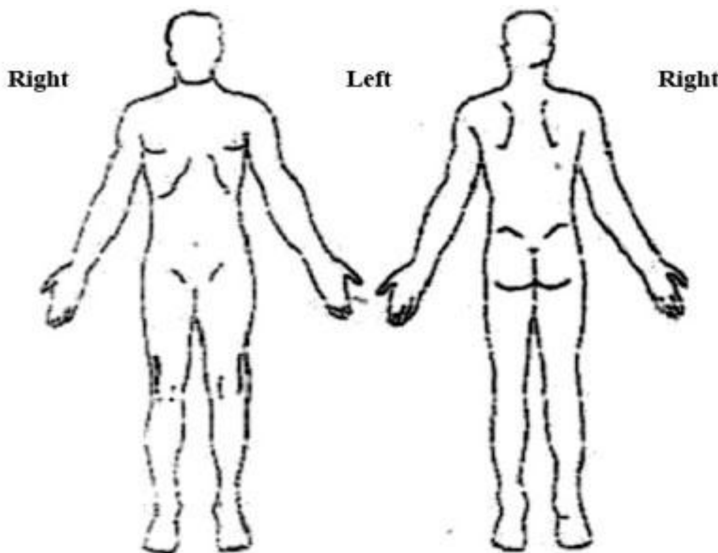
Confidential Patient History

Please list your current complaints in order of severity

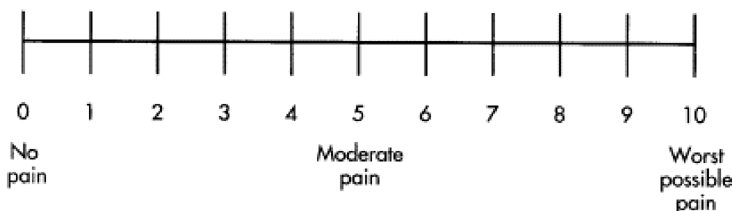
______________________	______________________	______________________
Main complaint	How long have you had this problem?	This episode?
Second complaint	How long have you had this problem?	This episode?
Third complaint	How long have you had this problem?	This episode?

Use letters below to indicate type of symptoms and location:

A- Ache **B-** Burning **S-** Stabbing
N- Numbing **P-** Pins & Needles **O-** Other



Please circle the severity of your main complaint (at its worst):



Have you had any tests done in the past (X-Rays, MRIs, CT Scans, bloodwork, etc.)? If yes, when?

____

Have you ever suffered from:

____ Dizziness ____ Arthritis
____ Diabetes ____ Sinus Trouble
____ Backaches ____ Neck Pain
____ Heart Trouble ____ Nervousness
____ Digestive Disorder ____ Headaches

How often do you experience these symptoms?

Constantly Frequently Occasionally Intermittently

Have you previously been treated for this condition?

Y / N If yes, when?

____

What are these conditions due to?

Auto Accident Work Injury Falling

Other ____________________

What makes it feel better?

Rest Heat/Ice Chiropractic Standing

Other ____________________

What makes it feel worse?

Sitting Bending Lifting Twisting Activity

Other_____________________

____
Name

_____/_____/________
Date

____

Whom may we thank for referring you?

____

Please list any medications

____

Please list any allergies to medications

____

Please list any surgeries you've had and their approximate dates

Does anyone in your family have a history of cancer, diabetes, heart disease, osteoporosis or strokes?   Y / N   If yes, please list relationship and which condition.

____

Have you ever smoked?   Y / N   Do you currently smoke?   Y / N   How much ____________

When is the last time you had a screening for colorectal cancer (Colonoscopy)? ____________

When is the last time you had a screening for breast cancer (Mammogram)? ______________

When is the last time you had a screening for cervical cancer (Pap test)? ________________

Have you had an Influenza vaccine this season?   Y / N   Approximate date: _____________

Have you had a pneumococcal vaccine?   Y / N   Approximate date: __________________

Over the past two weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Email: ____________________________

Mother's maiden name: ______________

Office use only

__________ Height   __________ Weight   __________ Pulse   _____/_____ BP

____
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Insurance: Most insurance policies cover chiropractic services, but the amount they pay varies per policy. As a courtesy we will verify your insurance benefits for you and review them with you. THIS DOES NOT GUARANTEE PAYMENT. Payment is subject to benefit limits and member eligibility at the time the claim is processed. If your insurance places a limit on the number of visits they will cover, you will be considered a cash patient once your limit is reached. Please read the “Cash” area below. Please note that it is your responsibility to track your visits. It must be fully understood that the type and number of covered services is defined by your insurance company, and that you are responsible for services not covered by your insurance. You will receive a monthly statement and we appreciate prompt payment of any balance due. Copays are due at the time of service.

Cash: If you do not have insurance, we request that you come prepared to pay in full for your first visit at the time of service. Subsequent appointment fees will reflect services rendered during each visit. Self-pay fees that are paid in full *at the time of service* will be offered a 20% discount.

Worker’s Compensation: If you are injured on the job, your employer’s Worker’s Compensation insurance will pay for care that is APPROVED by the Bureau of Worker’s Compensation. If your claim for treatment is denied, you are responsible for payment, either through your medical insurance or personally.
IMPORTANT: You must report your injury to your employer prior to your first visit.

Personal Injury/Auto Accident: If you have medical coverage on your auto insurance policy, we will bill them directly for payment for your care. If you do not have med-pay on your policy, or you are waiting for a settlement with another party such as an attorney, you will be expected to sign a lien which covers the doctor’s services through your settlement. **Regardless of any settlement, you, as the patient, are responsible for all medical bills. Responsibility for payment is not contingent on any settlement.**

All Patients Please Read: As stated above, insurance copays and cash patient payments are expected on the day of service. To accommodate you, we accept cash, personal check, money order, VISA and Mastercard in the office. For your convenience, we also offer a secure on-line system through which to pay bills and store credit cards and on-line signatures.

NOTE: There will be a $25.00 fee for any returned checks.

I have read and understand the office financial policy. This is an agreement between the doctor’s office and myself and failure to abide by this agreement could result in my account being turned over to an outside collection agency.

______________________________________ ____________
Patient or Parent/Guardian Signature Date

GENTNER Chiropractic CENTER
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Injury Questionnaire

Please answer all questions completely

Date of accident: ________/_______/_________ Time of accident: ______:_______ A.M. / P.M

Please explain in detail how your accident happened. ____
____
____

Where did you feel pain immediately after the accident? ____

List the extent of injuries as you know them. ____

Did you require post accident hospitalization? Yes / No If yes, were you admitted? Yes / No

Treatment administered: ____

Check symptoms you have noticed since the accident:

___ Headache
___ Light bothers eyes
___ Loss of memory
___ Hands are cold
___ Face flushed
___ Numbness in fingers
___ Loss of taste
___ Numbness is arm/s
___ Dizziness
___ Buzzing in Ears
___ Cold Feet
___ Fainting
___ Pins & needles in legs
___ Loss of smell
___ Chest pain
___ Other
___ Depression
___ Diarrhea
___ Stiff Neck
___ Problems sleeping
___ Constipation
___ Fever
___ Cold Sweats
___ Fatigue
___ Neck Pain
___ Pins & needles in arms
___ Loss of Balance
___ Tension
___ Irritability
___ Shortness of Breath
___ Upset stomach
___ Head feels heavy
___ Earls are Ringing
___ Back Pain
___ Nervousness
___ Numbness in Toes
___ Numbness in leg/s

Where did you go after the accident? ____

Did you return to work? Yes / No If yes, when did you return to work? ____

Did you go to the hospital? Yes / No If yes, please list any diagnoses or treatment. ____
____

Have you ever had an issue with the involved area prior to the accident? Yes / No If yes, did you ever receive treatment? Yes / No

Before the accident were you capable of working on an equal basis with others your age?

Yes / No Are your work activities restricted since the accident? Yes / No

Since the injury are your symptoms: Improving / Getting worse / Staying the same

13708 Madison Ave
Lakewood, Oh 44107
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Fax: 216-221-6446
www.gentnerchiro.com

PATIENT LIEN

To: ___________________

____

____

____

Re: ___________________________

Date of Injury/Accident: _________

Claim#: ________________________

I, ___________, do hereby authorize my attorney and/or insurance company (including Ohio Bureau of Workers' Compensation) to forward any and all payments to my physician, John F. Gentner, D.C. and/or Judith K. Gentner, D.C., for all treatments that I have received and/or will receive in connection with my treatment by either or both of them related to this accident claim.

By signing below, I acknowledge and agree that I am personally responsible for payment in full for all services rendered to me, and that this agreement is made solely for the doctor's additional protection and in consideration of treatments rendered and/or to be rendered. I further understand and agree that my obligation to pay for treatment in full is **not** contingent on any settlement, judgment, or verdict that I may eventually recover. I agree that I will provide a copy of this lien to any attorney that is representing or may in the future represent me in connection with this accident, and I hereby instruct my attorney, in the event of a settlement, judgment or verdict in my favor, to pay from the proceeds of that settlement, judgment, or verdict any amounts then due and owing to Ors. Gentner. I agree never to rescind this document and that any attempted rescission will not be honored by my attorney. I also understand and agree that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable in full.

If you have any questions about this matter, please contact our office.

______________________________ ______________________

Patient Signature Date

______________________________ ______________________

Attorney Signature Date