____
Chart Number

____/____/______
Date

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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**

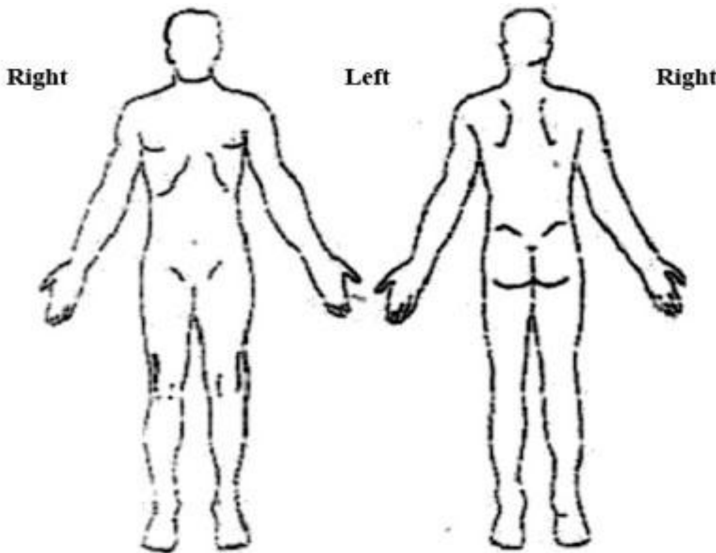
Confidential Patient History

Please list your current complaints in order of severity

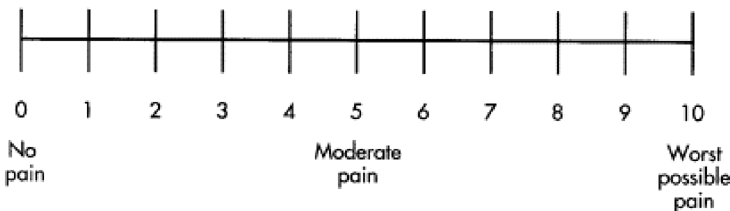
______________________________	________________________	____________________
Main complaint	How long have you had this problem?	This episode?
Second complaint	How long have you had this problem?	This episode?
Third complaint	How long have you had this problem?	This episode?

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 ____/____

Chart Number ______

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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