

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	
_____ 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

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?

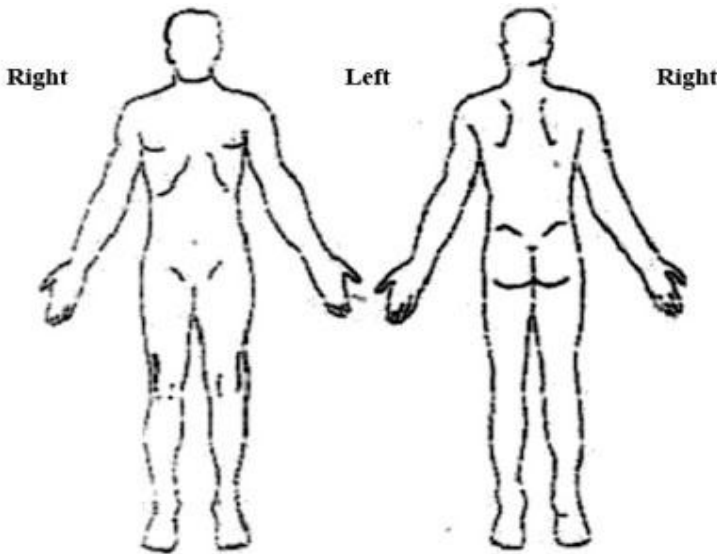
Auto Accident Work Injury Falling
Other _____

What makes it feel better?

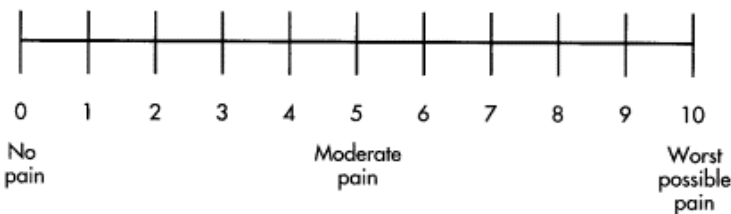
Rest Heat/Ice Chiropractic Standing
Other _____

What makes it feel worse?

Sitting Bending Lifting Twisting Activity
Other _____



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?

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
	0	1	2	3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless	0	1	2	3

Email: _____

Office use only

Height _____ Weight _____ Pulse _____ BP _____

Mother's maiden name: _____

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

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:

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

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
Phone: 216-221-2008
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