CRAM CHIROPRACTIC

Welcome To Our Office!

Date _____/_____/_____ **Gender** □ Male □ Female

Patient Name _____
first *middle* *last* *maiden*

Address _____
street *city* *state* *zip code*

Home Phone _____-_____-_____ **Cell Phone** _____-_____-_____ **Email** _____

Birthdate _____/_____/_____ **Age** _____ **Social Security #** __ __ __ - __ __ - __ __ __ __

Race □ White □ Black □ Asian □ Native American □ Native Hawiian □ Other/Multiracial_____

Ethnicity □Hispanic □Not Hispanic **Primary Language** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Spouse _____ **Spouse's Birthdate** _____/_____/_____

Emergency Contact _____ **Phone** _____-_____-_____ **Relationship** _____

How many children do you have? _____ **What are their ages?** _____

Employment Status □ Employed □ Unemployed □ Student □ Retired □ Stay-at-home

Occupation _____ **Employer** _____ **Work Phone** _____-_____-_____

How did you hear about us? □ Family □ Friend □ Co-Worker □ Google □ Office Website
□ Social Media □ Newspaper □ Radio □ Phone Book

If you were referred by a person may we thank them? □ Yes □ No **Person's Name** _____

Previous Chiropractic Care? □ Yes □ No **Chiropractor's Name** _____

If yes, for what problem? _____ **Date of Last Adjustment** _____/_____/_____

Who is your primary care physician? _____ **Phone** _____-_____-_____

Is today's visit due to a work-related injury or auto accident? □ yes □ no (*If yes, please see receptionist for additional paperwork)*

Reason For This Visit:

Primary Complaint _____

Secondary Complaint _____

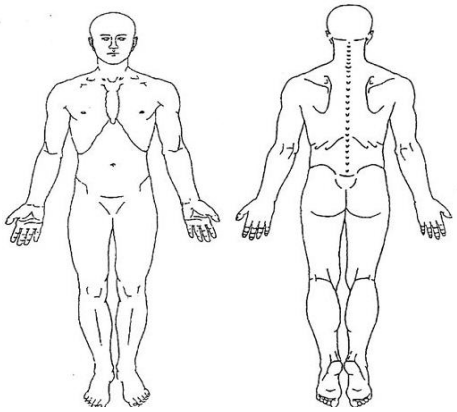
When did your symptoms start? _____ **What caused these symptoms?** _____

Have you seen another doctor, chiropractor, or other provider for this complaint? Who?_____

If yes, what tests were done and what treatments performed? (x-rays, MRI, CT, etc) _____

Have you experienced any of the following symptoms along with this complaint?
□ Fever/Chills □ Night Sweats □ Changes in bowel or bladder function □ Unexplained weight loss, fatigue, or blood loss
□ Dizziness/Vertigo □ Visual Disturbances □ Speech Alterations □ Weakness in arms or legs

Mark location of pain or symptoms:



Additional Health Information

Please List Your Current Medications *(If you have a list, we can make a photo copy)*

	Medication Name	*Dosage*	*Frequency*	*For What Condition?*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

What non-prescription drugs are you taking? □None □Tylenol □Advil □Ibuprofen □Aspirin □Other _____

What vitamins/supplements are you taking? □None □Multi-vitamin □Fish Oil □Probiotics □Vitamin D □Other_____

Please list any surgies you've had

1. _____ Date _____/_____/_____
2. _____ Date _____/_____/_____
3. _____ Date _____/_____/_____

Please mark any you currently have or have had previously:

Constitutional
□ Weight Loss/Gain
□ Fatigue

Eyes
□ Eye Pain
□ Double Vision
□ Change in vision

Ears, Nose, Throat
□ Difficulty Hearing
□ Ringing Ears
□ Vertigo
□ Sinus Trouble
□ Frequent Sore Throat

Respiratory
□ Cough
□ Coughing Blood
□ Wheezing

Cardiovascular
□ Chest Pain
□ Palpitations
□ Dizziness
□ Fainting
□ Shortness of Breath
□ Swollen Ankles

Gastrointestinal
□ Heartburn
□ Nausea/Vomitting
□ Constipation
□ Diarrhea
□ Change in Bowel Movements
□ Abdominal Pain
□ Black/Bloody Stool

Allergic/Immunologic
□ Hives/Eczema
□ Hay Fever

Genitourinary
□ Burning/Frequency
□ Nighttime
□ Blood in Urine
□ Erectile Dysfunction
□ Abnormal Discharge
□ Bladder Leakage

Musculoskeletal
□ Joint Pain/Swelling
□ Stiffness
□ Muscle Pain
□ Back/Neck Pain

Skin
□ Rashes/Sores
□ Itching/Burning

Neurologic
□ Loss of Strength
□ Numbness
□ Headaches
□ Tremors
□ Memory Loss

Psychiatric
□ Anxiety/Depression
□ Mood Swings
□ Difficulty Sleeping

Endocrine
□ Loss of Hair
□ Heat/Cold Intolerance

Hematologic/Lymphatic
□ Easy Bruising
□ Gums Bleed Easily
□ Enlarged Glands

What type of care are you interested in? *(Check all that apply)*
□ Pain Relief □ Complete Resolution of Current Condition □ Improved Athletic Performance □ Healthy Lifestyle/Wellness

We are going to address your main concern, but if we could help you with your other health and wellness goals, is that something that you would want to discuss? □ Yes □ No

Your Health Goals:

1. _____
2. _____
3. _____

The above information is true and accurate to the best of my knowledge.

Signature_____ **Date** _____/_____/_____

Patient's Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This office encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my responsibilities.

Initial

Notice of Privacy Practices

Our office is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledges that I have received, reviewed, and understand and agree to the Notice of Privacy Practices of Cram Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by Cram Chiropractic.

Initial

Release of Protected Health Information

I give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner.

Initial

Financial Policy

In an ongoing effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have established a single fee schedule that applies to all patients for each service provided. Payment is expected at the time of service. Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. We cannot guarantee your coverage, even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed. Any balance remaining after insurance benefits are obtained is the responsibility of the patient. Any non-covered services are the responsibility of the patient at the rate determined by in-network or out-of-network rates as determined by the insurance company's explanation of benefits. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit. We understand that there are times of financial difficulty and we are willing to work with you. However, if you have not come to us to discuss your payment options, all balances remaining unpaid after 60 days may be turned over to a collection agency. It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage. Cram Chiropractic cannot guarantee exact details at any given time. We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

Initial

Method of Payment *(Select your method of payment)*

- □ Cash: 10% discount for payment at time of service, 15-20% discount for prepay options *(ask for details)*
- □ Primary Insurance _____, Secondary Insurance _____
- □ Medicare, Secondary Insurance _____
- □ Medicaid: *(circle one)* Amerigroup, United HealthCare
- □ Motor Vehicle Accident/Work-Related

Assignment of Benefits

Assignment of benefits is simply authorizing Cram Chiropractic to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes Cram Chiropractic to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office. I understand that I may withdraw my signature at any time. I also understand that I am ultimately responsible for all charges for which my insurance does not pay.

Initial

Signature _____ **Date** _____/_____/_____