Confidential Patient Data

PATIENT INFORMATION

Name:____ Date of Birth:________________

Address:____ City:_________________ State:_________

Zip:___________ Social Security #:____________________ Age:______ □Male □Female □Unspecified

Home Phone:__________________ Cell Phone:_______________ Work Phone:___________________

Email: ___________________________________

Your Occupation:___________________________ Your Employer:_____________________________

Marital Status: ❑Married ❑Single ❑Divorced ❑Separated ❑Other _____________________________

Spouse's Name:__________________________________ Number of Children:__________________

Spouse's Employer:_______________________________ Spouse's Work Phone:________________

Medical Doctor's Name:____________________________________ Phone:_______________________

Would you like a report sent to your M.D.? No❑ Yes❑

In Case of Emergency contact:________________________ Phone:__________________________

Relationship:____

Referred to this Office by: ❑Friend/Family Member - Name?__________________________________
❑Internet ❑Mail ❑Health Fair ❑Family Doctor ❑Other______________________________________

Payment for Services will be by: □Cash □Health Savings Account □Health Insurance □Automobile Insurance

Please complete the following insurance information, if you have not already provided it to our office:
Name of Insurance Co.:____________________________ Insured's Name:_________________________

Insured's Date of Birth:_____________________________ Relationship to Insured:__________________

Name of Secondary Insurance Co:______________________ Insured's Name:_______________________

Insured's Date of Birth:_____________________________ Relationship to Insured:_________________

Optional questions:
Race *(check one)*
❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Other ______________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown
Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*
❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Japanese ❑ I choose not to specify ❑ Other _____________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

On your initial visit, we will be addressing your top 3 complaints. Please list in order of priority.

1.____

2.____

3.____

Name and location of doctors previously seen for present condition(s):

____

Have you been treated by a chiropractor for either current or previous conditions?

If so, date of last adjustment?____

Have you been treated by a physician for any healthcare conditions in the last year?

❑Yes ❑No Describe Condition____

Date of Last Physical Exam____

SURGICAL HISTORY:

1.____ Date:________________

2.____ Date:________________

Have you ever had a metal implant? ❑Yes ❑No ____

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. ________________________Date:________________

❑Job ❑Auto ❑Other 2.________________________Date:________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Please list current medications.
If there are no current medications, please check here: ❑

Medication:	Dosage:	Frequency:
______________________________	____________________	__________________
______________________________	____________________	__________________
______________________________	____________________	__________________
______________________________	____________________	__________________
______________________________	____________________	__________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

_______________________________________ _________________________________

_______________________________________ _________________________________

Physical Therapy Relative Contraindications:

The following list consists of conditions which may contraindicate using certain physiotherapeutic modalities we have in our physical therapy/rehabilitation room. Please read through this list carefully and circle any of the following that you may have. Also list the year or date that you first had the disorder or procedure/implant and any details you can provide.

Y N Tumor
Y N Tuberculosis
Y N Pregnancy Date of last Menstrual Period:
Y N Pacemaker
Y N Blood Clots or Phlebitis
Y N Problems with circulation
Y N Use of anticoagulant(blood thinner)
Y N Metallic implant or joint replacement
Y N Surgical clips, shrapnel or other metal fragments
Y N Skin diseases or rashes
Y N Hypersensitivity to hot/cold
Y N Intrauterine device or I.U.D.
Y N Vasculitis/Raynaud's
Y N Impaired sensation or loss of feeling

I hereby certify that the above statements are true to the best of my knowledge.

Signature ____ Date ______________________

Patient Name: ______________________________

ASSIGNMENT OF INSURANCE BENEFITS: I authorize and direct that payment be made directly to:

Dupont Chiropractic Resource Center
1960 E. Dupont Rd.
Fort Wayne, IN 46815

For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_______________ _______________
Date Patient Initials

RELEASE OF INFORMATION: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan of Medicare.

_______________ _______________
Date Patient Initials

PAYMENT AGREEMENT: I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible
for all remaining charges.

_______________ _______________
Date Patient Initials

FINANCIAL AGREEMENT: Payment is expected at the time of service unless prior arrangements have been made. Returned checks and balances over 30 days may be subject to additional collection fees. I agree if I should not pay my balance in a reasonable time frame or establish a payment schedule, that I will be sent to collections. If such occurs I agree to pay balance incurred, 3% monthly interest and attorney fees.

_______________ _______________
Date Patient Initials

MISSED APPOINTMENT FEE: You may incur a $25.00 fee for missed appointments and appointments cancelled without 24 hours advanced notice.

_______________ _______________
Date Patient Initials