

FOCUS

CHIROPRACTIC & WELLNESS

Guiding people to new heights of health
One patient at a time

Welcome to our office!

Please fill out our New Patient Entrance Form as completely and accurately as possible. If you have any questions, please feel free to ask our qualified Chiropractic Assistant.

It is our pleasure to be of service to you. Our commitment to you is to promise the highest quality of health and well being with Chiropractic care.

Tell Us About You

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____
Cell Phone (_____) _____
Birthday _____ Age _____
Gender Male Female No. of children _____
Employer _____
Work Address _____
Work Phone (_____) _____
Type of Work _____
Marital Status Married Single Divorced
 Separated Widowed
Social Security # _____
Email Address _____

Tell Us About Your Family

Spouse's Name _____
Child's Name _____ Age _____
Child's Name _____ Age _____
Child's Name _____ Age _____
Child's Name _____ Age _____

Reason For This Visit

Describe the purpose of this visit _____

Is the purpose of this appointment related to:

Job Sports Auto Fall

Chronic Discomfort Home Injury Other

Please explain: _____

If job related, have you made a report of your accident to your employer? Yes No

When did this condition begin? _____

Has this condition gotten worse stayed constant
 comes and goes

Does this condition interfere with?

work sleep daily routine other activities

Please explain _____

Has this condition occurred before? Yes No

Explain _____

Have you seen other doctors for this condition?

Yes No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

Experience With Chiropractic

Who referred you to this office? _____

Have you been seen by a Chiropractor before? _____

Reason for those visits? _____

Doctor's Name _____

Approximate date of last visit? _____

Has any *child* in your family seen a Chiropractor? Yes No

Past Traumas

Have you ever had? Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury

Please Explain: _____

Have you had in other trauma in the past? _____

Have you ever had any surgeries or hospitalizations? If so, please explain _____

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and other for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Symptomatic relief of pain or discomfort
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Wellness Care:** Keeping your body functioning at it's optimal level and highest state of health so you can continue doing the things you want to do as long as you want.
- I want the Doctor to select the type of care appropriate for my condition

Patient's Signature

Date

Medications I Now Take

- | | |
|--|---|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Pain Killers (including Aspirins) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood Pressure Medicine | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> _____ |

Health Habits

- | | No | Yes |
|----------------------------|--------------------------------------|--|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink coffee? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise regularly? | <input type="checkbox"/> No | <input type="checkbox"/> Moderate <input type="checkbox"/> Daily |
| Do you wear | <input type="checkbox"/> Heel lifts | <input type="checkbox"/> Sole lifts |
| | <input type="checkbox"/> Inner Soles | <input type="checkbox"/> Arch Supports |

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | |
|---|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Congenital Heart Detect |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Surgery/ Pacemaker |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Difficultly Breathing |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Numbness or Pain in | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Arms/Legs/Hands | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Problems |

For Women Only:

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control? Yes No
- Do you experience painful periods?
 Yes No
- Do you have irregular cycles? Yes No
- Do you have breast implants? Yes No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

Patient Signature

Date

Guardian or Spouse's Signature

Date

Who should receive bills for payment on your account?

- Patient Spouse Parent Worker's Comp.
 Medicare Personal Health Insurance Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payment to the Doctor for X-rays is for examination of X-rays only. The X-rays negatives will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____ Policy # _____

Address _____ Group # _____

Phone Number _____

About the Insured Person

Name _____ Insured's Social Security # _____

Relation _____ Date of Birth _____



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Office Fees and Financial Policy

<u>Service</u>	<u>Fee</u>
Consultation	No Charge
Initial Examination/Nervous System Scans	\$70-\$150
X-rays (3 Views)	\$60
Progress Examination	\$45
Adjustments	\$35-\$45

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees; therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you.

Important: All client’s are responsible for full payment for the first visit (unless other arrangements have been made in advance.)

Today’s payment will be made with: (Please circle one) Cash Check Credit Card

Insurance: We will verify all insurance and your benefits per your agreement with your carrier. After verification, the Doctor will give his recommendations and an appropriate plan will be designed for each individual. All patients are responsible for payment of care. If your insurance covers any or all of care, you will be paid directly from your insurance company after your claims are submitted.

Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Focus Chiropractic & Wellness with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

(Patient’s Name)

(Patient’s Signature)

Date: _____