Pine Lake Chiropractic Clinic, P.S.

Confidential Patient Information

Patient Contact Information:

Last Name:_____ **First:**_____ **Initial:**____
Nick Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Birth Date:_____ **Gender:** (□Male □Female)
Occupation:_____

Home Phone:_____
Cell Phone:_____
Work Phone:_____ Ext:____
Email:_____
Marital Status: (□S □M □W □D □Partnered)
Employer:_____

Whom may we thank for referring you? (□Insurance □Phone Book □Web Search □Drive By □Other:_____)

Partner/Parent/Guardian/Emergency Contact:

Name:_____ **Relationship**_____
Cell Phone:_____
Address:_____ **Home Phone:**_____
Work Phone:_____

Patient Symptoms:

Is your condition due to an accident that that resulted from an automobile or work related injury? (□No □Yes)

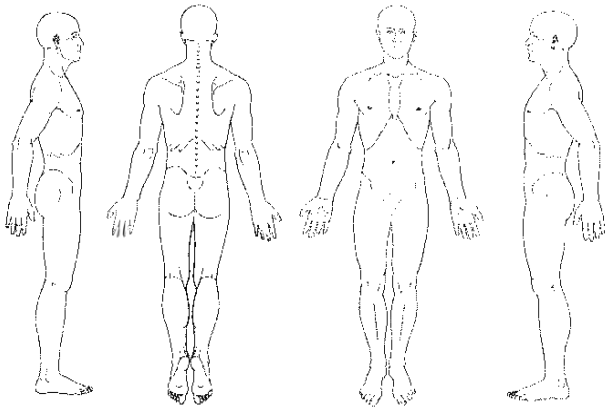
Please explain the primary reason for your appointment, specific areas of pain, discomfort and all recent injuries:_____

When did your symptoms first appear_____
What caused your condition?_____
Over the past: (Days_____ Weeks_____ Months_____ Years_____)
My condition has been getting: □Gradually Worse □Rapidly Worse □Staying About the Same □Getting Better
Activities or movements painful to perform: □Sitting □Standing □Walking □Bending □Lying Down □Other:_____
Interferes with your: □Work □Sleep □Daily Routine □Recreation

I would describe my pain as: (circle as many as apply)

CONSTANT	FREQUENT	INTERMITTENT	OCCASIONAL
VERY SEVERE	SEVERE	MODERATE	DULL
STABBING	SHARP	ACHING	MILD
BURNING	TINGLING	THROBBING	NUMBNESS
SHOOTING	STIFFNESS	SWELLING	OTHER:_____

PLEASE INDICATE AREAS OF DISCOMFORT



What is your pain on a scale from 1(least) to 10 (severe)_____
How often do you have this pain?_____
Is it constant or does it come and go? _____
I have tried the following solutions for this problem:
_____
_____

New to Chiropractic: (□No □Yes) **Previous Chiropractic Care:** (□No □Yes)
Dr:_____ When?_____
For treatment of:_____
Was there a specific treatment that was successful?_____
Present Family Doctor:_____ **Phone Number:**_____

Other Doctors consulted for these health problems:
Dr. Name:_____ When:_____
Diagnosis:_____ Treatment:_____
How long did you see the Doctor?_____ How frequently?_____
Results:_____

Exercise/or Work Level:		Exercise:	Lifestyle:	Family:
□ None	□ Sitting	□ Swimming	□ Smoking (Pack/Day:_____)	# Infant(s) under 2:_____
□ Daily	□ Standing	□ Biking	□ Coffee/Caffeine (Cups/Day:_____)	# Children: _____
□ Moderate	□ Light lifting to 20#	□ Jog/Run	□ Alcohol intake (Drinks/Week:_____)	# Care giver for:_____
□ Heavy	□ Heavy lifting +20#	□ Yoga	□ High Stress (Reason:)_____	
□ Other:_____			□ Other:_____	

Current Medication:	Adverse Side Effects or Allergies:

Injuries/Surgery:	Date/Year:	Description:
Falls/Accidents:	□No □Yes	
Head Injuries:	□No □Yes	
Broken Bones/Dislocations:	□No □Yes	
Previous Hospitalizations:	□No □Yes	
Surgeries:	□Head □Neck/Throat □Back □Abdominal □Chest / Heart / Lungs □Other:_____	

Financial Responsibility and Insurance Information: ***Please give your insurance card and photo ID to the front desk to copy***

Who is responsible payment? □Self □Other:_____(Relationship to patient):_____

Financial Policy:

Full payment is expected at the time of service. Payments accepted are cash, check or credit card.

IF you have insurance, we will make a copy of your card and collect any co-pay or co-insurance that is due. As a courtesy, our office will contact your insurance company to obtain a benefit quote. If there is a balance after your insurance processes the claim, we will forward you a statement. Insurance coverage varies greatly, if you have questions, feel free to contact our office and we will do our best to assist you. Ultimately, you are responsible for any care that your insurance does not cover.

Pine Lake Chiropractic Clinic also accepts Personal Injury Protection claims resulting from motor vehicle accidents and Workers Compensation claims to treat injured workers. Prior approval must be obtained with these cases before care can commence. You will also be required to complete an "Accident Form" in addition to the regular "Intake Forms"

Pine Lake Chiropractic is also a provider for Medicare. You will be required to read and sign the separate Medicare policy documentation.

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the HIPPA *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.,* which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X_____ _____

Signature of Patient

_____ _____

Printed Name **Date**

Consent For Treatment Of Minors Or Dependants:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X_____ _____

Signature of Parent or Guardian **Date** **Relationship to Patient**