Confidential Patient Information

Welcome to Dominion Family Chiropractic Center. If you have any questions while filling this form out, please do not hesitate to ask. We are always happy to answer any questions you may have.

Note: If you have RECENTLY been involved in an automobile injury, this is not the correct form for you – please request our accident report form from the front desk.

Name_____ Sex M F Date _____

Address_____ City _____ State_____ Zip_____

Phone #s: Home: _____ Work:_____ Cell:_____

E-mail address: _____

Date of Birth:_____/_____/_____ Age: _____Marital Status: Married Single Widowed

Social Security #_____-_____-_____ Employer/Occupation: _____

Emergency Contact Name: _____ Phone #_____

How did you hear about us? _____

Referred By: _____ Current Primary Care Physician:_____

Health Insurance Information: Do you have health insurance? Yes No

Please give your insurance card to the receptionist.

Company:_____ Policy / Group # _____

Are you the primary policy holder? Y N If not, please fill in the following information:

Primary policy holder's name: _____ Date of Birth:_____/_____/_____

Relationship to you: (circle) Spouse Parent Other

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Were your results satisfactory? Y N

All medical facilities have been requested by the U.S. Government to obtain the following information. It is used for statistical purposes only.

Race: (please circle one) American Indian Black or African American Asian Hispanic Pacific Islander Alaskan Native Native Hawaiian White Latino Other

Health History

1. Are you under the care of another doctor? Yes No

2. If so, for what condition / conditions?

_____

3. Past Health History:

Check the following conditions you may have had or do have now:

____Alcoholism	____Diabetes	____Irregular Cycles	____Numbness
____Allergy	____Diarrhea	____Low Blood Sugar	____Pleurisy
____Anemia	____Ears Ringing	____Malaria	____Pneumonia
____Arteriosclerosis	____Eczema	____Measles	____Polio
____Arthritis	____Emphysema	____Menstrual Cramps	____Rheumatic Fever
____Asthma	____Epilepsy	____Migraine	____Scoliosis
____Backaches	____Gall Bladder	____Miscarriage	____Sinus
____Back Pain	____Gout	____Multiple Sclerosis	____Stroke
____Cancer	____Headaches	____Mumps	____Thyroid Problems
____Chest Pains	____Heart Attack	____Muscle Spasms	____Tuberculosis
____Constipation	____Heart Disease	____Neck Pain	____Ulcers
____Convulsions	____High Blood Pressure	____Nervousness	____Whooping Cough
____Depression	____Indigestion	____Neuritis	____Other_____

4. Previous injuries or trauma:_____

5. Have you ever broken any bones? _____ If yes, which bones? _____

_____

6. Allergies _____

7. Medication Reason for taking

_____ _____

_____ _____

_____ _____

8. Surgeries: Type Date

_____ _____

_____ _____

_____ _____

9. Females - Pregnancies:

Pregnancies / Date of Delivery C-Section / Other Complications

_____ _____

_____ _____

_____ _____

Is there a possibility you are pregnant? Yes or No

Health History Continued

10. Family Health History:

Major health problems of close relatives: _____

11. Height: _____ Weight: _____

12. Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

13. Lifestyle:

A. How often do you exercise? _____

B. Are you on a special diet? _____

14. Smoking History:

A. Have you ever smoked? Y N (if no, please go to the next page.)

B. Approximate date you started smoking: _____

C. Do you currently smoke? Y N If NO, when did you stop? _____

D. If you are currently smoking, how often do you smoke? (circle one below)

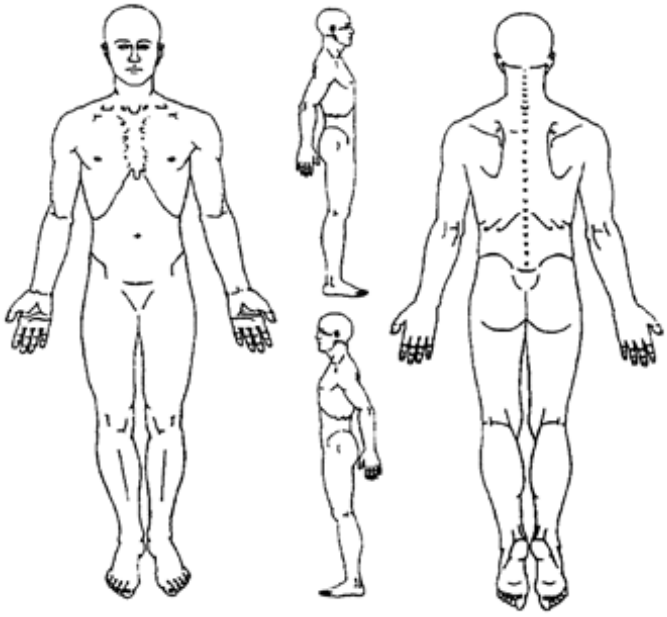
Daily OR Every once in a while

The Reasons for Your Visit Today

1. Why are you being seen today? List all reasons.

_____

_____



2. Using the diagram on the right, please circle the area / areas that you feel pain.

3. For each area of pain, please answer the following questions: Please put your primary complaint in Area 1 and your secondary complaint in Area 2.

Area 1 Location (Primary Complaint):

_____

1. Using the pain scale below, please circle the number that best describes the pain as you usually feel it.

0 1 2 3 4 5 6 7 8 9 10

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

No Pain Minimal pain Mild pain Moderately Severe pain Remarkably severe

2. What do you think may have caused this pain to start? _____

_____

3. Can you pinpoint a date that this pain began? Y N Date:_____

4. If a date cannot be given for #3, how did the pain begin? Circle one of the following:

Started gradually & became worse over time OR Has come and gone for a long time

5. When the pain begins, how long does it usually last? _____

6. Describe the type of pain you are currently experiencing. (check all that apply)

□ Aching □ Throbbing □ Stabbing □ Shooting □ Sharp □ Dull □ Burning □ Cramping
□ Stiffness □ Swelling □ Numbness □ Tingling □ Other, describe it: _____

7. Is there any time of the day when the pain is worse or better?

Yes or No if so, please circle one of the below
My pain is **worse** during the AM or PM. My pain is **better** during the AM or PM.

The Reasons for Your Visit Today Continued

8. Does the pain in this area seem to radiate to other areas? Yes OR No

   If the pain radiates, where does it radiate to? (circle one)
   Up Down Left Right All Around

9. What activities make the pain worse?
   □ Sitting □ Sleeping □ Standing □ Looking up □ Looking down □ Typing
   □ Sneezing □ Walking □ Coughing □ All movement □ House chores □ Bending
   □ Straining □ Exercise □ Rest □ Stooping □ Reaching □ Lifting
   □ Laying on my back □ Laying on my stomach □ Twisting □Driving
   □ Stair Stepping □ Other, describe it: _____

10. What helps ease the pain? _____

11. What daily activities does this pain affect? _____

12. What are some things you can no longer do since the pain began? _____
    _____

13. Previous interventions, treatments, medications, surgery, or care you've sought for this pain:
    _____
    _____

Area 2 Location (Secondary Complaint): _____(if you have a third area of pain, please let our Chiropractic Assistant know and she will give you another form)

1. Using the pain scale below, please circle the number that best describes the pain as you usually feel it.

0 1 2 3 4 5 6 7 8 9 10

No Pain Minimal pain Mild pain Moderately severe pain Severe pain Remarkably severe

2. What do you think may have caused this pain to start? _____
   _____

3. Can you pinpoint a date that this pain began? Yes/ No Date:_____

4. If a date cannot be given for #3, how did the pain begin? Circle one of the following:

   Started gradually & became worse over time OR Has come and gone for a long time

The Reasons for Your Visit Today Continued

5. When the pain begins, how long does it usually last? _____

6. Describe the type of pain or you are currently experiencing. (check all that apply)

□ Aching □ Throbbing □ Stabbing □ Shooting □ Sharp □ Dull □ Burning □ Cramping
□ Stiffness □ Swelling □ Numbness □ Tingling □ Other, describe it: _____

7. Is there any time of the day when the pain is worse or better?

Yes or No if so, please circle one of the below
My pain is **worse** during the AM or PM. My pain is **better** during the AM or PM.

8. Does the pain in this area seem to radiate to other areas? Yes OR No

If the pain radiates, where does it radiate to? (circle one)
Up Down Left Right All Around

9. What activities make the pain worse?
□ Sitting □ Sleeping □ Standing □ Looking up □ Looking down □ Typing
□ Sneezing □ Walking □ Coughing □ All movement □ House chores □ Bending
□ Straining □ Exercise □ Rest □ Stooping □ Reaching □ Lifting
□ Laying on my back □ Laying on my stomach □ Twisting □Driving
□ Stair Stepping □ Other, describe it: _____

10. What helps ease the pain? _____

11. What daily activities does this pain affect? _____

12. What are some things you can no longer do since the pain began? _____
_____

13. Previous interventions, treatments, medications, surgery, or care you've sought for this pain:
_____
_____

Dominion Family Chiropractic Center
Dr. Barry H. Stewart D.C.
630-B Cedar Road
Chesapeake, VA 23322
(757) 547-4000
www.dominionchiropractic.com

Office Policies

APPOINTMENTS:
Please arrive on time for your appointments. The doctor does his best to stay on schedule and needs your cooperation. If you are unable to keep an appointment for any reason, make sure your reschedule to maintain the frequency of care that is needed to improve your condition.

CANCELLATION/NO SHOW POLICY:
This policy is to assure that patients have access to care when needed and to avoid the great expense to our office due to late cancellations and no shows. We take your time very seriously and are committed to serving you with the highest level of care possible. 24 hour notice is required to change or cancel an appointment. We understand that things can come up. If you need to reschedule or cancel your appointment, please give us as much notice as you can so we can give your spot to someone else that is waiting for help.
If you call with less than 24 hour notice or if you don't call at all, we reserve the right to bill you for the time slot we saved for you. The cancellation/no show fee is $25 per appointment. We understand there are unpredictable situations that cannot be helped, so please contact us to explain your unique situation.

CELL PHONE POLICY:
Please turn your cell phone on silent while you are in the office as a courtesy to the doctor, staff, and other patients.

I have read and understand the above Office Policies. As an active patient of Dominion Family Chiropractic, I will adhere to these policies.

Signature:_____ Date:_____

Assignment, Acknowledgment, and Understanding

Assignment of Payment: My insurance company is hereby requested to pay directly to Dominion Family Chiropractic, PC any monies due on the account. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy, or if for any reason the insurance company refuses and/or fails to pay my claim.

Unpaid Insurance Balance: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, any information needed for this or related Medicare claims.

Obligation As To Services: I hereby acknowledge that I am receiving (or am about to receive) health care services at Dominion Family Chiropractic and that I have been advised that Dominion Family Chiropractic is willing to wait for payment for these services; so long as there continues to be a likelihood that payment will be made by my insurance company.

I understand and agree that payment of services at Dominion Family Chiropractic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment if:
1. It is determined that there is no insurance company obligation to pay for Dominion Family Chiropractic's services; or
2. The insurance company for the undersigned refuses to acknowledge an assignment to Dominion Family Chiropractic or it is needed to take other actions for the protection of the interest of Dominion Family Chiropractic.

Interest and Collection: I acknowledge and agree that Dominion Family Chiropractic shall be entitled to reimbursement from me for the fees of any collection agency, which may be based on a percentage at a maximum of 12% of the debt, and all costs and expenses, including reasonable attorney fees that Dominion Family Chiropractic may incur in any collection efforts. I understand that at the time my account becomes 45 days delinquent, it will be placed with a collections agency and a $50.00 billing fee will be added to the account balance.

Privacy Policy: I acknowledge that I have read, or had the opportunity to read, Dominion Family Chiropractic's Notice of Privacy.

By my signature below, I make the foregoing authorizations, assignments and agreements.

Name of person responsible for payment:_____

Patient Name (Please print) _____

Patient Signature: _____ Date _____

Dominion Family Chiropractic
630-B Cedar Road
Chesapeake, VA 23322
757-547-4000

I, _____, give permission for the staff of Dominion Family Chiropractic, PC, to obtain verification of my health care benefits by means of obtaining a copy of my Summary Plan Description to include the Certificate of Coverage, as well as any Material Modifications which affect those benefits.

Patient signature: _____

Patient's printed name: _____

Date: _____