CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**:_____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile**: _____ **Work**: _____

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth:_____ **Occupation:** _____ **Employer:**_____

Spouse/Significant Other: _____ **Children and Ages:**_____

Who may we thank for referring you to our office?_____

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:_____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Name of Previous Chiropractor:** _____

Home: _____ **Mobile**: _____ **Date of Last Chiropractic Adjustment**: _____

Relationship: Child / Parent / Spouse / Other: _____ **Primary Care Physician**: _____

Doctor's Phone: _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

PRIMARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name:_____ **Gender**: M / F

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ **Date of Birth**: _____

SECONDARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name:_____ **Gender**: M / F

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ **Date of Birth**: _____

List all Medications With Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

_____

_____

_____

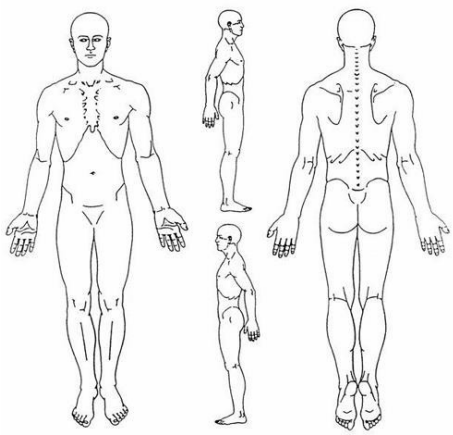
CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

What Bothers You The Most Today: _____

When Did It Begin (date):_____**How Did It Begin:** _____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **Where:** _____

Draw Areas of Complaints:



Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb

Is The Complaint: Constant / Off and On

What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds *(Advil, Tylenol, etc.)* / RX Meds

What Makes It Worse? Sit / Stand / Walk / Lying / Sleep / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other:_____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other:_____**When and Where:**_____

Any Other Complaints:_____

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

Does anyone in your IMMEDIATE family have a history of (circle condition): **NONE**

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____Type_____ **Other Relevant Family History**:_____

Allergies to Medications: *(List and reactions)*_____

_____

Vitamins & Supplements: *(List all and frequency*)_____

_____

PAST HEALTH HISTORY: *(List even if it was 20 years ago…)*

Surgeries – Date, Type and Reason:_____

_____

_____

_____

Injuries, Traumas or Hospitalizations: *(Even 20 years ago or more)*

_____

_____

_____

_____

SOCIAL AND OCCUPATIONAL HISTORY:

Highest Level of Education:

High School / Some College / College Grad / Post Grad / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

_____

Habits:

Cigarettes – (#/day/years) _____

Alcohol – (amount/day)_____

Coffee/Tea – (cups/day)_____

Rec. Drugs: (list) _____

Consents

Please check all boxes and sign below

☐ **Consent to Bill/Collect Insurance**: I consent, if I am using a third party for payment of my services (health insurance, auto accident, worker's compensation, Parent/Guardian, etc.) to allow Complete Care Chiropractic KC to submit all necessary information needed to receive payment for services I received to these third parties. I further consent to accept assignment of payments from my insurance company to paid directly to the office.

☐ **Consent to Examination and Treatment**: I give the doctors and staff of Complete Care Chiropractic KC permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

☐ **Consent to Retrieve Medical Records**: I give the doctors and staff at Complete Care Chiropractic KC permission to obtain all medical records from other providers, offices or hospitals which may assist in my care.

☐ **HIPPA:** A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are your parents/guardian if you are a minor, or whomever is responsible for your bill (i.e. insurance company, third party or attorney if you have one).

☐ **Clinical Summary Report (CCR):** I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Complete Care Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me.

_____ _____ _____

Name Patient/Guardian Signature Date

Pregnancy Waiver (Women Only): By my signature, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

_____ _____ _____

Name Patient/Guardian Signature Date

NON-COVERED SERVICES

The following are not covered by major medical insurance or Medicare:

Acupuncture

Hot Laser

Muscle Stimulation (United Healthcare, Blue Cross Blue Shield, Medicare)

Disc Decompression

Supplements

Supports

Exam and X-rays are **NOT** covered by Medicare

NON-INSURANCE COSTS

Examinations: $100.00

X-Rays: $50.00 - $150.00

Spinal Adjustments: $55.00

Signature: _____

Date: _____

Financial Policy

As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note, your health insurance contract is between you and your insurance company. Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us.

If your carrier has not paid the claim in sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within 90 days, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you do not have insurance, all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed **$200.00** or care may be terminated. If your balance become higher, you must have a credit card.

If you have insurance, all deductible and co-insurance balance are expected at the time of service. Your co-insurance balance may not exceed **$200.00** or your care may be terminated.

If you discontinue care for any reason other then discharge by the doctor, all balances will be come immediately due and payable in full by you regardless of claim submitted.

Patients Printed Name: _____

Signature:_____ Date: _____

For your convenience you may retain your credit card on file with us

Credit Card number:_____ Exp date: _____

Name as it appears on card:_____ CVV:_____