



## Confidential Patient Information

---

The following information is needed in order to better serve you. Please complete all questions.  
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: M S W D No. of Children \_\_\_\_\_

Referred by: \_\_\_\_\_ E-mail \_\_\_\_\_

Would you like to sign up for our Email Newsletter? (No Spam)  Yes  No

Please Check Type of Payment:  Cash  Check  MasterCard/Visa

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years on Job: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do You Have Health Insurance?  Yes  No Insurance Company: \_\_\_\_\_

Insurance Plan/Group#: \_\_\_\_\_ Your Work Hours: \_\_\_\_\_

Do You Have Medicare?  Yes  No Medicaid?  Yes  No

Name of Spouse or Parent: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Describe The Major Complaints That Bring You To Our Office: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Your Condition Due To An Accident?  Yes  No Date of Accident: \_\_\_\_\_

Type of Accident?  Auto  Work/Job  At Home  Other

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature (For Minors): \_\_\_\_\_ Date: \_\_\_\_\_



# Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

List All Current Health Problems and from 1-10 rate their severity: (1=minor, 10=severe)

1.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10
2.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10
3.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10
4.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10
5.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10
6.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	1	2	3	4	5	6	7	8	9	10

List Your Top 3 Health Goals:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What Health Changes/Improvements do you hope to gain while undergoing care in our office? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you taken ANY prescription or over-the-counter medications in the last 6 months?    Yes                      No

If Yes, describe what condition/symptom the medication was for: \_\_\_\_\_

\_\_\_\_\_

List All Past Surgeries: \_\_\_\_\_

\_\_\_\_\_

List any past traumas and their dates (if possible): (car accidents, sports injuries, slips and falls, etc)

\_\_\_\_\_

\_\_\_\_\_



## Health History

---

### **Please Check The Conditions You Have Or Have Had:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Epilepsy                       |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) |
| <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Crohn's Disease                |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Trigeminal Neuralgia (TN)      |

### **Please Check All Present Symptoms:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Migraine Headaches     | <input type="checkbox"/> Pain in hip      | <input type="checkbox"/> Problems sleeping |
| <input type="checkbox"/> Non-Migraine Headaches | <input type="checkbox"/> Pain down leg    |  |
| <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Knee pain        | <input type="checkbox"/> Area of numbness  |
| <input type="checkbox"/> Dizziness or Vertigo   | <input type="checkbox"/> Lower back pain  | <input type="checkbox"/> In arms           |
| <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Swelling in legs | <input type="checkbox"/> In hands/fingers  |
| <input type="checkbox"/> Allergies              |   | <input type="checkbox"/> In legs           |
| <input type="checkbox"/> Loss of coordination   | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> In feet/toes      |
| <input type="checkbox"/> Muscle weakness        | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Other _____       |
|   | <input type="checkbox"/> Hemorrhoids      |  |
| <input type="checkbox"/> Pain in neck           | <input type="checkbox"/> Painful periods  | <input type="checkbox"/> Pins & needles    |
| <input type="checkbox"/> Stiffness in neck      | <input type="checkbox"/> Bed wetting      | <input type="checkbox"/> In arms           |
| <input type="checkbox"/> Pain in shoulders      |   | <input type="checkbox"/> In hands/fingers  |
| <input type="checkbox"/> Pain across shoulders  | <input type="checkbox"/> Nervousness      | <input type="checkbox"/> In legs           |
| <input type="checkbox"/> Mid-back pain          | <input type="checkbox"/> Irritability     | <input type="checkbox"/> In feet/toes      |
| <input type="checkbox"/> Pain in buttocks       | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Other _____       |

Please list any additional information that you would like us to know concerning your health: \_\_\_\_\_

---

---

---

---

---

---

---



## Patient Consent for Use & Disclosure of Protected Health Information

---

With my consent, Midwest Upper Cervical may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Midwest Upper Cervical Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Midwest Upper Cervical reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Midwest Upper Cervical.

With my consent, Midwest Upper Cervical may call my home phone or other designated location and leave a message on voice mail or in person in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Midwest Upper Cervical may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Midwest Upper Cervical's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Midwest Upper Cervical may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

### Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Authorization to Pay/Release Is Granted to: **Midwest Upper Cervical***



## Financial Office Policy

---

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).
5. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient, it is your responsibility to take care of the co-payment and any non-covered services. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.
8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. All insurance payments, regardless of which company issues a check, are first applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.
11. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
12. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
13. If you change insurance companies or employers, you agree to provide this office with current information immediately.
14. This office accepts, Mastercard, Visa, Cash and Personal Checks.
15. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

---

***Patient Signature***

***Date***



## X-Ray Consent

---

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

I understand that my doctor may need x-rays in order to diagnose my condition, and I give permission for all needed diagnostic tests.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **Females Only:**

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date