Back On Track Physical Medicine

It's your future... Be there healthy!

PERSONAL INFORMATION

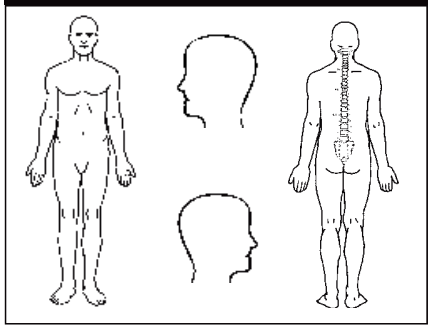
TYPE OF PAYMENT: ☐ *Cash* ☐ *Check* ☐ *Health Ins*

First Name:_____ Last Name: _____ MI_____
Date: _____ Address: _____
City/State/Zip: _____ Home Phone: _____
Work Phone: _____ Mobile Phone: _____
Email: _____ Social Security #: _____
DOB: _____ Age: _____ Sex: ☐M ☐F Marital Status: ☐ S ☐ M ☐ D ☐ W
Spouses Name: _____ # of Children: _____ Occupation: _____
Employer's Name: _____ Work Address: _____
City/State/Zip: _____ Do you have a Primary Care Physician? ☐Yes ☐No
How were you referred to our office?: ☐Yellow Pages ☐Drive By ☐Newspaper ☐TV ☐Friend ☐Other
Have you ever seen a Chiropractor Before? ☐Yes ☐No If Yes, When: _____
Where: _____ Results:_____

MAJOR COMPLAINT INFORMATION

What is/are your complaint(s)?: _____
_____
When did these symptoms begin?: _____ Has this condition existed in the past?: ☐Yes ☐No
These symptoms were a result of: ☐Auto Accident ☐Work Injury ☐Other _____
Is this condition getting progressively Worse? ☐Yes ☐No ☐Constant ☐ Comes & Goes
Is this condition interfering with your ☐Work ☐Sleep ☐Daily Routine ☐Other _____
How long has it been since you felt good?: _____
List other doctors who have treated this condition: _____
Have you been in an auto accident: ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

Please mark your areas of pain on the figures below:



If this is an injury, please describe what happened.

_____
_____
_____
_____
_____
_____

CHECK THOSE ACTIVITIES BELOW DURING WHICH YOU EXPERIENCE DIFFICULTY OR PAIN

☐ Lying on back ☐Lying on side with knees bent ☐ Lying flat on stomach ☐ Turning over in bed
☐ Walking ☐Stooping ☐ Sitting ☐ Bending forward ☐ Bending backward ☐ Dressing self
☐ Getting in/out of car ☐ Gripping ☐ Climbing ☐Pushing ☐ Pulling ☐ Reaching
☐ Standing for periods over one hour ☐Sneezing ☐Coughing ☐ Other: _____

HABITS

☐ Smoking Packs/Day: _____
☐Alcohol Drinks/Day: _____
☐ Coffee Cups/Day: _____
☐ Soft Drinks Drinks/Day: _____
☐Water Glasses/Day: _____
☐ Vitamins List: _____

EXERCISE

☐ N o n e
☐ 1-2 days/week
☐ 3-4 days/week
☐ 5+ days/week
Type _____

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EMERGENCY CONTACT

Name: _____ Relation: _____
Home Phone: _____ Work Phone: _____
Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Primary Insurance Info:
Insurance Company: _____ Policy Number: _____
☐HMO ☐PPO Policy Holder's Name: _____ Policy Holder's DOB: _____
Policy Holders' S.S. Number: _____ Relation to Patient _____
Group #: _____ Insured Place of Employment: _____
Employee ID# _____ Co-Payment: ☐ Y ☐ N If So, Amount: $_____
Deductible ☐ Y ☐ N If so, Amount: $ _____ Has your deductible been satisfied? ☐ Y ☐ N

Do you have a Secondary Policy? ☐ Yes ☐ No
Insurance Company: _____ Policy Holder's Name: _____
Relation to Patient _____Policy Holders' S.S. Number: _____
Policy Number: _____
Insured Place of Employment: _____

FAMILY HISTORY

Please √ all that apply

	Stroke	Bad Posture	Heart Trouble	High Blood	Cancer	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Diabetes
Father																
Mother																
Brother																
Sister																
Child																
Child																
Child																

ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: _____
_____
Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No
If so, please list: _____
_____
Any additional information you would like the doctor to know about before beginning care at Back on Track Physical Medicine?_____
_____

Back On Track Physical Medicine

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Back on Track Physical Medicine. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.
If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.
This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.
I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.
Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.
I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Back on Track Physical Medicine responsible for any errors or omissions that I may have made in the completion of this form

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following: The doctor will not be held responsible for any pre-existing medically diagnosed conditions.
Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.
Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional whom we feel can further assist you.
I hereby authorize the doctors and staff affiliated with Back on Track Physical Medicine to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

RECORDS RELEASE

To _____, I hereby authorize you to release to Back On Track Physical Medicine any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

Signature of Staff: _____ Date: _____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he may designate for assistance to administer chiropractic care as he deems necessary to my _____ (indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____

Signature of Staff: _____ Date: _____