# Chiropractic Case History/Patient Information

**Date:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Emergency Contact:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:**

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

# History of Present and Past Illness:

Chief Complaint: Purpose of this appointment:_____

Date of symptoms appeared or accident happened:_____

Is this due to: Auto_____ Work_____ Other_____

Have you ever had the same or similar condition? Yes No If yes, when and describe:

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):_____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? Yes No

If yes, describe:_____

Do you have any allergies of any kind? Yes No

If yes, describe:_____

Do you have any congenital condition? Yes No

If yes, describe:_____

Women: are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

| | | | |
|---|---|---|---|
| Headaches | _____ Frequency_____ | Loss of Balance | _____ |
| Neck Pain | _____ | Fainting | _____ |
| Stiff Neck | _____ | Loss of Smell | _____ |
| Sleeping Problems | _____ | Loss of Taste | _____ |
| Back Pain | _____ | Unusual Bowel Patterns | _____ |
| Nervousness | _____ | Cold Feet | _____ |
| Tension | _____ | Cold Hands | _____ |
| Irritability | _____ | Arthritis | _____ |
| Chest Pains/Tightness | _____ | Muscle Spasms | _____ |
| Dizziness | _____ | Frequent Colds | _____ |
| Shoulder/Neck/Arm Pain | _____ | Fever | _____ |
| Numbness in Fingers | _____ | Sinus Problems | _____ |
| Numbness in toes | _____ | Diabetes | _____ |
| High Blood Pressure | _____ | Indigestion Problems | _____ |
| Difficulty Urinating | _____ | Joint Pain/Swelling | _____ |
| Weakness in Extremities | _____ | Menstrual Difficulties | _____ |

N = Now P = Previously

| | | | |
|---|---|---|---|
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Fatigue | _____ | Depression | _____ |
| Lights Bother Eyes | _____ | Loss of Memory | _____ |
| Ears Ring | _____ | Buzzing in Ears | _____ |
| Broken Bones/Fractures | _____ | Circulation Problems | _____ |
| Rheumatoid Arthritis | _____ | Seizures/Epilepsy | _____ |
| Excessive Bleeding | _____ | Low Blood Pressure | _____ |
| Osteoarthritis | _____ | Osteoporosis | _____ |
| Pacemaker | _____ | Heart Disease | _____ |
| Stroke | _____ | Cancer | _____ |
| Ruptures | _____ | Coughing Blood | _____ |
| Eating Disorder | _____ | Alcoholism | _____ |
| Drug Addiction | _____ | HIV Positive | _____ |
| Gall Bladder Problems | _____ | Ulcers | _____ |

## Social History

Please indicate beside each activity whether you engage in it:

OFTEN = O SOMETIMES = S NEVER = N

| | | | |
|---|---|---|---|
| Vigorous Exercise | _____ | High Stress Activity | _____ |
| Moderate Exercise | _____ | Family Pressures | _____ |
| Alcohol Use | _____ | Financial Pressures | _____ |
| Drug Use | _____ | Other Mental Pressures | _____ |
| Tobacco Use | _____ | Other (specify) | _____ |
| Caffeine | _____ | _____ | |

# Financial Policy of The Amato Chiropractic & Rehabilitation Clinic, P.C.

Chiropractic care is covered under most insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

**Patients without Insurance**

We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been made. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Mastercard, or Visa.

**Group or Individual Insurance**

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles, or copays.

**Worker's Compensation**

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

**Personal Injury or Automobile Accidents**

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if any attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

**Medicare**

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you do not have secondary coverage you are required to pay the deductible and the remaining 20% as well as any non-covered services. If you have secondary coverage they will pay the remaining 20%. Our office completes and files the forms for Medicare at no charge.

I have read and understand the payment policy of The Amato Chiropractic & Rehabilitation Clinic, P.C. I understand that my insurance is an arrangement between myself and my insurance company, NOT between The Amato Clinic and my insurance company. I request that The Amato Clinic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Amato that fees will be due and payable immediately. Balance may be sent to collections if payments are not received nor payment arrangements made along with a 10% interest charge.

_____

Patient's signature Date