Patient Information (Please print with pen)

Legal Last Name:	Legal First Name:	Middle Name:	SSN:

Mailing Address:	City:	State:	Zip:	Email Address:

Home Telephone:	Cell Phone:	Other Phone:	Gender: □ M □ F	Status: □Married □Single □Widowed □Divorced

Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: □Yes □No	Auto Related: □ Yes □ No

If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No
Name of Facility_______________________

If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No If so, do you know if you have exceeded the Medicare cap? □ Yes □ No

If Medicare, are you currently receiving Home Health Services: □ Yes □ No
Type of service: If yes, Name of Agency:_____________________________________ Date of Last Service:

Physician Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here:
May we send medical information to your PCP? □ Yes □ No		City/State of Referring Physician:

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ Other ______________________

Mother's Full Legal Name:	Home Phone:	Address (if different):
Date of Birth:	Employer:	
Father's Full Legal Name:	Home Phone:	Address (if different):
Date of Birth:	Employer:	

Emergency Contact

Contact Name:	Phone:	Relationship:

Health Care Primary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):		
Employers Name:	Relationship to patient: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):		
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □Other______________		

Authorization: I, with my signature, authorize Hometown Health to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize Hometown Health, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to Hometown Health, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the “Practice’s” privacy policy as required by law. I request the following restrictions be placed on the “Practice’s” use and/or disclosure of my health information (leave blank if NO).

____

____

____

Patient/Guardian:____Date:_______

____

Chiropractic Medical Questionnaire

Patient Name (Print) ____ Date __________________________________

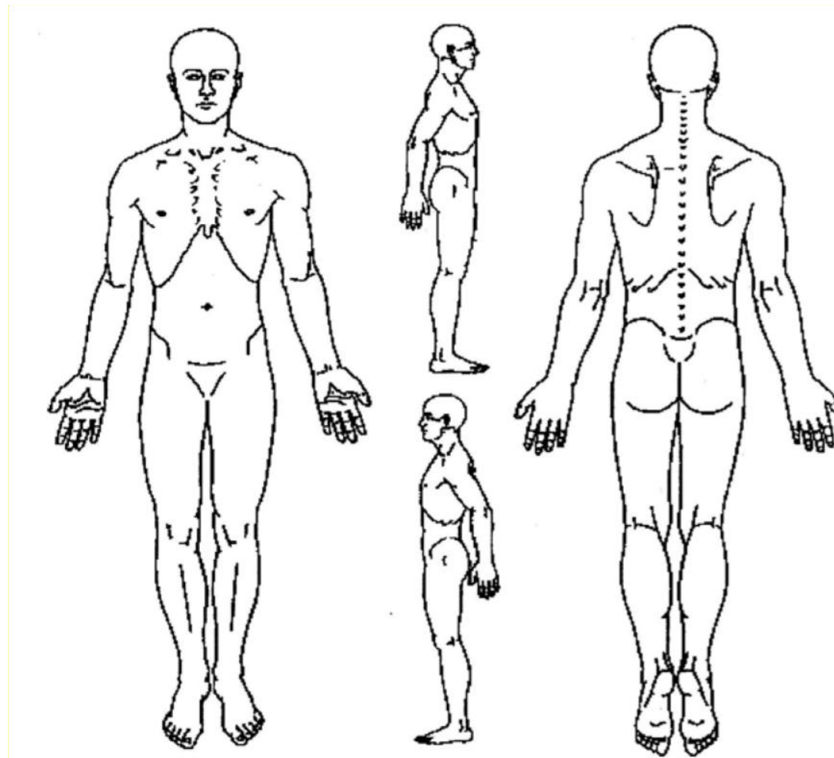
Age: _________ Gender: F M Dominant Hand: R L

Family Doctor: ____ Who referred you to this office? ___________________________________ May we contact your Family Doctor? Y N

What is the main reason for this visit? ____

On the diagram below, please indicate where you are experiencing pain right now and use the appropriate symbol as indicated

A = Ache B = Burning N = Numbness P = Pain PN = Pins & Needles S = Stabbing SF = Stiffness W = Weakness O = Other



Please make a slash through this line as to the level of your current pain

No Pain At All -- Worst Pain Possible

Rate the **severity** of your pain from 1 (least pain) to 10 (most pain) (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **type** of your pain? Sharp Dull Stabbing Throbbing Aching Burning

Is your pain: Constant Intermittent (comes and goes) Shooting Cramping Tingling

Does your pain awake you from sleep? Y N Does your pain interfere with your daily routine/recreation? Y N

Estimate the average hours of sleep each night: _________ Estimate how many times you are awakened each night _____________________

Do you have: Numbness Weakness Swelling Weight Changes Changes in bowel/bladder frequency or urgency Night Sweats Dizziness Lightheadedness Stiffness Bruising Loss of control of bowel or bladder functioning

Since your problem started is it: Getting Better Getting Worse Unchanged

What makes your symptoms **worse**? Standing Walking Lifting Exercise Twisting Bending Squatting Kneeling Sitting Coughing Sneezing Lying Down: On side On back On stomach Using Stairs: Up Down Both

What makes your symptoms **better**? Rest Elevation Ice Heat Position ______________ Other ___________________________

Have you taken any medications/OTC medications today? Y N Last time taken? ______________________________________

What vitamins/supplements are you currently taking? Please list with dosage: ____

____

Hometown Health

CHIROPRACTIC HEALTH AND FAMILY HISTORY FORM

HEALTH HISTORY

Have you had any of the following:

Condition	Yes No	Condition	Yes No	Condition	Yes No	Condition	Yes No
AIDS/HIV	Yes No	Emphysema	Yes No	Miscarriage	Yes No	Scarlet Fever	Yes No
Alcoholism	Yes No	Epilepsy	Yes No	Mononucleosis	Yes No	Stroke	Yes No
Allergy Shots	Yes No	Fractures	Yes No	Multiple Sclerosis	Yes No	Suicide Attempt	Yes No
Anemia	Yes No	Glaucoma	Yes No	Mumps	Yes No	Thyroid Problems	Yes No
Anorexia	Yes No	Goiter	Yes No	Osteoporosis	Yes No	Tonsillitis	Yes No
Appendicitis	Yes No	Gonorrhea	Yes No	Pacemaker	Yes No	Tuberculosis	Yes No
Arthritis	Yes No	Gout	Yes No	Parkinson's Disease	Yes No	Tumors, Growths	Yes No
Asthma	Yes No	Headaches	Yes No	Pinched Nerve	Yes No	Typhoid Fever	Yes No
Bleeding Disorders	Yes No	Heart Disease	Yes No	Pneumonia	Yes No	Ulcers	Yes No
Breast Lump	Yes No	Hepatitis	Yes No	Polio	Yes No	Urinary Tract Infections	Yes No
Bronchitis	Yes No	Hernia	Yes No	Prostate Problem	Yes No	Vaginal Infections	Yes No
Bulimia	Yes No	Herniated Disk	Yes No	Prosthesis	Yes No	Venereal Disease	Yes No
Cancer	Yes No	Herpes	Yes No	Psychiatric Care	Yes No	Whooping Cough	Yes No
Cataracts	Yes No	High Blood Pressure	Yes No	Rheumatoid Arthritis	Yes No	Other ____________________	
Chemical Dependency	Yes No	High Blood Cholesterol	Yes No	Rheumatic Fever	Yes No	____________________	
Chicken Pox	Yes No	Kidney Disease	Yes No				
Depression/ Anxiety	Yes No	Liver Disease	Yes No				
		Measles	Yes No				

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day ______________
Moderate	Standing	Alcohol	Drinks/Week ______________
Daily	Light Labor	Coffee/Caffeine	Cups/Day ______________
Heavy	Heavy Labor	Drinks	Drinks/Day ______________
		High Stress Level	Reason ______________

Are you pregnant? Yes No Due Date ________________

Injuries/Surgeries you have had	Description	Date
Falls	________________________	____________
Head Injuries	________________________	____________
Broken Bones	________________________	____________
Dislocations	________________________	____________
Surgeries	________________________	____________

FAMILY HISTORY

Have your immediate family members had any of the following:

High Blood Pressure	HIV Positive	Back Problems	Headaches
Heart Disease	Asthma	Ulcer or Stomach Problems	Thyroid Disease
Emphysema	Diabetes	Stroke	Circulation Problems
Seizures-Convulsions	Kidney Diseased	Arthritis-Rheumatism	Cancer
Mental Illness	Osteoporosis		

Hometown Health

Patient Legal Name: ____
First MI Last

CONDITION/ACCIDENT/INJURY DETAILS

Symptoms first begin on: _____/_____/_____ or have been experiencing for ______days ______ weeks ______months ______ years.

What symptoms are you experiencing? ____

____

What body parts are affected? ____

____

Have any of these body parts been injured before? YES NO If yes, please describe: ____________________

____

What medications are you currently taking? ____

____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). ____

____

____

Will you seek payment from another party? YES NO If yes, who? Worker's Compensation Motor Vehicle Accident Other

If an attorney is involved, please provide name, address, and phone number: ____________________

____

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _________/_________/_________ State Accident Occurred: ______________________ Time: ______________

Auto Insurance Name: ____________________________ Adjuster's Name: ____________________

Adjuster's Phone Number: ____________________________ Name of Insured: ____________________

Claim Number: ____________________ Policy Number: ____________________ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

AUTHORIZATION

I, with my signature, authorize **Hometown Health,** and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Hometown Health**, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: ________________________________ Date: ____________________

Hometown Health

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. 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, Discover, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. 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. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (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 present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

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 the 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. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

I have read and understand the payment policy of Hometown Health. I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between Hometown Health and my insurance company. I request that Hometown Health 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 the doctors at Hometown Health that fees will be due and payable immediately.

____ ____________________

Patient/Guarantor Signature **Date**