Wieging Physical Medicine, LLC

3435 Farm Bank Way Grove City, Ohio 43123
(614) 539-0405 (p) - (614) 539-0554(f)

Acct # ___________________

Confidential Patient Information

Patients Name: ________________________________ Sex [] M [] F Age: __________

Address:________________________________ Marital Status: Married [] Single [] Divorced [ ] Widowed [] Separated [ ]

City: _________________________ Zip:__________

Home Phone: ________________________________ Date of Birth: _________________________________

Cell Phone: ___________________________________ Social Security #:________________________________

Email:____

Occupation:____________________________________ Employer/School:_______________________________

How did you hear about our office? Referred By?

Ins. Company: _________________________________ Ins. Phone #: ____________________________________

ID#: ____ Group #: ____

Name of Policy Holder: __________________________ Policy Holder Birth date: ___________________________

Policy Holder Employer: _________________________ Policy Holder SS#:

Patients relationship to the policy holder: [ ] Self [ ] Child [ ] Spouse

Secondary Ins. Company: _________________________ Ins. Phone #______________________________________

ID#:____ Group #: ____

Name of Policy Holder:___________________________ Policy Holder Birth date: ____________________________

Policy Holder Employer: Policy Holder SS#:

Family Physician:____Physician's Phone______________________________

Physician's address ____

Person to contact in case of emergency (Name & Phone #): ____

Have you ever been under Chiropractic Care? (Y / N) If so, with who? _______________________________________

What is your goal in our office? ____

What is/are your Chief Complaint(s)? ____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Wieging Physical Medicine, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered at above clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor/clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor/clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor/clinic to release any and all medical information to other health care providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I may be personally billed $20-$40 for missed massage or physical therapy appointments when I do not provide 24 hour notice of cancellation.

I have read and fully understand this agreement.

____ Signature

______________________ Date

Wieging Physical Medicine, LLC (cont.)

Acct # ______________

ACCIDENT INFORMATION

Is condition due to an accident? *YES* *NO* If yes, type? *AUTO* *WORK* *HOME* *OTHER* ______________

To whom have you made a report? ____

Claim # ______________________________ Claim Phone # ______________________ Attorney Name __________

HEALTH HISTORY

Have you received any of the following treatments for your condition? *Chiropractic* *Physical Therapy* *Medication* *Surgery* *Other*

Date of Last: Physical Exam_____ Spinal X-ray ______ Spinal Exam ______ Blood Test ______ Urinalysis ______ MRI/CT Scan ______
(MO/YR)

Have you had any of the following? Please mark a "Y" to indicate YES or a "N" to indicate NO:

AIDS/HIV		Hepatitis		Pinched Nerve	
Appendicitis		Hernia		Pneumonia	
Arthritis		Herniated Disc		Polio	
Asthma		Herpes		Prosthesis	
Bleeding Disorders		High Cholesterol		Psychiatric Care	
Bronchitis		Kidney Disease		Rheumatoid Arthritis	
Cancer		Liver Disease		Stroke	
Diabetes		Migraines		Thyroid Problems	
Emphysema		Miscarriage		Tonsillitis	
Epilepsy		Multiple Sclerosis		Tuberculosis	
Fractures		Osteoporosis		Tumors, Growths	
Gout		Pacemaker		Typhoid Fever	
Heart Disease		Parkinson's		Ulcers	
				Medical, Mechanical or Electrical Implants	
				Other:	

Exercise: *None* *Light* *Moderate* *Heavy*

Habits: *Smoking* ______ *per day* *Alcohol* _______*per week* *Coffee/Caffeine*______ *per day*

Are you pregnant? Yes No If yes, due date ______________

Please list any head injuries, broken bones, surgeries or serious illnesses/diseases:

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name ______________________________________ Pharmacy Phone # __________________________