Patient Name:_____ Today's Date: ___/___/___

Birth Date: ____/____/____ Age: _____ Gender: F M

Date of Exam: ___/___/___ Provider: Dr. David DeOliveira New Patient☐ Yes ☐ No

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

E-Mail:_____

CURRENT ADDRESS

Street_____

City _____State _____ Zip_____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____Work Phone (_____) _____

Student at _____☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____Spouse's Date of Birth ____/____/____

Spouse's Occupation _____Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐FULL-TIME ☐PART-TIME

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

☐No particular condition or symptoms -- Just seeking general good health

Is your condition or injury due to an accident or work-related cause? ☐YES ☐NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐YES ☐NO

Did it result from a *work-related* accident or cause? ☐YES ☐NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Please describe how your **PRIMARY** complaint occurred and what region of the body is affected:

_____

_____

_____

Describe your pain: ☐Burning ☐Sharp ☐Dull ☐Ache ☐Tingling ☐Numbness ☐Weakness☐Stiffness ☐Other _____

Pain rating of your condition: ☐0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10

No Pain Worst Pain

Has the Patient ever had the same or similar conditionor symptoms previous to this most recent occurrence?☐ Yes ☐ No

When? ___/___/___

What aggravates it?
_____

What relieves it?
_____

Please describe how your **SECONDARY** complaint occurred and what region of the body is affected:
_____
_____
_____

Describe your pain: ☐Burning ☐Sharp ☐Dull ☐Ache ☐Tingling ☐Numbness ☐Weakness ☐Stiffness ☐Other _____

Pain rating of your condition:☐0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10

No Pain Worst Pain

Has the Patient ever had the same or similar conditionor symptoms before this most recent occurrence?☐ Yes ☐ No

When? ___/___/___

What aggravates it?
_____

What relieves it?
_____

Have you missed work or school due to your injuries?☐ Yes ☐ No

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Date of last physical examination? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe:_____

What medications or drugs are you taking? _____

Please check any of the following symptoms you are now experiencing:

☐Face Flushed	☐Headache	☐Dizziness	☐Nausea	☐Light Bothers Eyes	☐Neck Stiff
☐Head seems too heavy	☐Neck Pain	☐Tingling arms/hands	☐Pain arms/hands	☐Numbness arms/hands	☐Hands Cold
☐Loss of strength - arms	☐Buzzing/ringing Ears	☐Jaw pain	☐Sharp/shooting pain	☐Tension	☐Clumsiness
☐Loss of Smell	☐Back Pain	☐Pain in legs/feet	☐Tingling in legs/feet	☐Numbness legs/feet	☐Feet Cold
☐Loss of Memory	☐Sleeping Problems	☐Constipation	☐Nervousness	☐Loss of Balance	☐Cold Sweats
☐Irritability	☐Chest pain/rib pain	☐Diarrhea	☐Burning muscle pain		
☐Loss of strength - legs	☐Difficulty swallowing				

Other _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Condition	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

Medical History:

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

_____

Surgeries/Hospitalizations/Fractures: _____

Have you ever suffered from?:

☐Dizziness ☐Arthritis ☐ Digestive Disorders ☐Backaches ☐ Headaches

☐ Nervousness ☐ Heart Disease ☐Stroke ☐High Blood Pressure ☐Numbness

☐High Cholesterol ☐ Sinus Trouble ☐ Diabetes ☐ Asthma ☐ Anemia

☐ Hernia ☐ Neuritis ☐Cancer (Type)_____

Do you now or have you ever had:

☐Heart Disease ☐Diabetes ☐Cancer☐Stroke☐High Blood Pressure☐Thyroid Problems☐Tuberculosis☐Prostate Disorder

Allergies (please list all): _____

☐Kidney Problems☐Asthma ☐Ulcer ☐Seizure Disorder☐Other: _____

Have you experienced changes to:

☐Eyes (sight) ☐Ears (hearing) ☐Nose (smell) ☐Mouth (taste) ☐Bladder

☐Bowels ☐Sleep ☐Emotion ☐Appetite

Please Explain: _____

Social History:

Do you smoke? ☐ Yes ☐No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐No Number of Drinks _____

Level of stress in your life: None ☐ Mild ☐ Moderate ☐ Severe

Do you drink coffee? ☐ Yes ☐No Number of cups _____

Do you exercise? ☐ Yes ☐No Number of days/week_____

Sleep Hrs/Night _____

Vitamins _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____Date of Birth: ____/____/____ Phone: (_____) _____

Mother: _____Date of Birth: ____/____/____ Phone: (_____) _____

Guardian: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Who do you normally live with? □ Mother and Father □ Father □ Mother □ Legal Guardian □ None of these

As parent/legal guardian of above child, I understand the terms above and grant permission for treatment.

Parent/Guardian Signature: _____ Date:_____

PERSONAL GOALS

1. What are your favorite hobbies to do now? _____
2. How are your current problems affecting these activities or hobbies? _____
3. Goal(s) you would like to achieve in this office. _____

ON A SCALE OF 0-10 (0 BEING THE LEAST AND 10 BEING THE MOST)

_____How committed are you to being at your maximum health potential?

If not 8-10, please explain._____

_____How important is it for your family to be at their optimal health potential? If not 8-10, please explain.
_____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEMS?

_____Temporary relief (help the symptom, but do not fix the problem.)

_____MAXIMUM CORRECTION (CORRECT THE CAUSE OF THE PROBLEM FOR MAXIMUM STABILITY IN THE FUTURE)

IF YOU HAVE PREVIOUSLY SEEN A CHIROPRACTOR, PLEASE DESCRIBE YOUR LIKES AND DISLIKES (IF ANY), SO WE MAY BETTER SERVE YOU. _____

_____

Informed Consent

I hereby request and consent to the performance of: physical examination, any other diagnostic tests such as x-rays to diagnose my condition(s), and treatment(s). This consent will cover the entire course of my treatment(s) for present conditions or any future conditions for which I seek treatment(s).

Patient Signature: _____ Date: _____

In case of emergency, contact _____ Phone #: _____

Insurance Information:

Do you have health insurance? □ YES □ NO □ Not Sure Company:

_____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/_____ Does the policy holder have the insurance through his/her employer? □ YES □ NO If yes, who is the employer?

_____

****

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any

usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/_____

- We invite you to discuss with us all questions regarding our services and fees.
- The best health care is based on a friendly, mutual understanding between doctor and patient.
- All services are to be paid at the time they are rendered unless other arrangements are specifically made with a patient service representative.
- Your first two visits are always payable at time of service.
- To establish a credit account with this office, a credit card imprint must be on file.

FINANCIAL OPTIONS:

- Pay by cash, check or credit card at the time of service or once per week. An account balance may not exceed **$150.00**. If you have insurance, as a service to you, we will submit all necessary claim forms and documentation directly to your insurance company. Or, if you wish, we will provide you with all documentation and you can submit it yourself.

- Establish a payment plan with our office. Together, we can calculate a fair weekly or monthly payment amount that fits in with your budget. Again, if you have insurance, all necessary documentation will be either submitted to your insurance company or provided to you.

- In a limited number of cases, we can accept assignment on your insurance claim, meaning we will accept the insurance company's portion of the bill directly and you are responsible for any outstanding balance that they do not cover. To qualify for assignment,YOU MUST:

  - Have your insurance verified to meet our standard of acceptance.
  - Provide us with a fully completed claim form from your insurance company.
  - You are responsible for all deductibles, co-payments and non-covered services, in other words, any balance your plan does not cover.
  - After 60 days, if the insurance company does not settle your account, you are responsible for payment of all charges.
  - ***If you terminate your care plan prematurely, you are responsible for the full balance due on your account at that time.***

  - After the 3rd notice of unpaid charges or balance, the account will be sent to a collections agency. The account holder will be responsible for all additional charges such as:
    - Collections fee – 50% is added to the original bill by the collection agency
    - Lawyer fees
    - Court fees
    - Interest of 1.5% monthly

Please remember that an insurance plan is a legal agreement between you and your insurance company. We will do our best to help you obtain the maximum reimbursement you are entitled to under your plan. But please remember that, in many instances, we have no control over their capricious and arbitrary system of handling your claims and we assume no responsibility as to their final decision.

I have read and fully understand the policies as set forth above and accept full financial responsibility for all services rendered in this office.

Signature: _____ Date: ____/____/_____

I have assigned my insurance company payments directly to Chiropractic For Wellness (CFW), however I understand that it is possible that payment will be made directly to me. If I do not reimburse CFW the amount I receive from the insurance company within 5 days of their payment to me, I hereby authorize the CFW to charge my:

Visa/MC/Discover/AMEX account #_____ with expiration date of _____

the amount of reimbursement taking into consideration all deductibles, co-payments, and policy provisions.

I understand that if I am inadvertently overcharged I will receive a refund immediately.

Signature: _____ Date:____/_____/_____