Patient Name_____Date_____

# Welcome to Align Chiropractic

200 W. Wisconsin Ave P: (920) 720-6300
Neenah, WI 54956 F: (920) 720-6315

## Patient Information

Date:_____
Patient Name:_____
Address:_____
City:_____
State:_____ Zip:_____
E-mail:_____
Sex: M or F circle one
Age:_____Birthdate:_____
Married/Single Spouse's Name_____
Your Occupation:_____
Employer/School_____
Whom may we thank for referring you?_____
_____
Home Phone: (____) _____
Cell Phone: (_____) _____
Work Phone: (_____)_____
Emergency Contact Name:_____
Emergency Contact Phone:_____

## Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to the doctors at Align Chiropractic LLC all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## Align Chiropractic Policies:

We are happy to serve you as a patient. Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve our goal, we need your commitment as well:

*We urge our patients to follow the Doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of improvement we both desire, instructions for care must be followed.

*In order to file your claims in a timely manner we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for chiropractic care. ***However, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers, and what it doesn't.***

*Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.

*Payment for non-covered services, deductible and co-payment amount are due on the day of service.

*Accounts past 30 days old with no attempt at payment may be subject to an 10% annual finance charge, which will be added monthly to that account.

*If you have any questions about your individual insurance or any of our financial policies, please ask to speak to the front desk. If you need to make special arrangements, please ask. **We will never deny care to anyone based solely on ability to pay.** We will do everything possible to meet your financial needs.

_____ _____
Signature Date

Patient Name_____Date_____


# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT TO CHIROPRACTIC TREATMENT.

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices (HIPPA policies) and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice, and Informed Consent to Chiropractic Treatment at Align Chiropractic LLC

_____ _____

Date Patient Signature

_____

Patient Name

_____

Witness Signature

Patient Name_____Date_____

# History of Current Complaint and Health History

Major Complaint(s): Please include when it first occurred, description of pain and rate the pain on a scale of 1-10, 10 being the most severe.

_____
_____
_____

Known cause of complaints (Accident or Work Injury?) & have you had this before?

_____
_____
_____

Does the pain radiate?_____Associated signs/symptoms_____

Methods of Treatment attempted result:_____
_____

What makes it worse? ____Sitting____Standing____Walking____Coughing____Driving
____Sleeping____Bending____Sneezing____Other:_____

Time of the day or night that is worst?_____

Have your symptoms_____Improved_____Worsened_____Stayed Same

How has the pain affected your daily life?_____

Is there a family history of any of the following? Please list the relation if so.
Current Complaint_____
Thyroid Problems_____
Cancer_____
heart disease/stroke_____
Diabetes_____
Arthritis_____
Other_____

Have you had chiropractic care in the past? Yes No Last visit_____
Name of Chiropractor_____Results/Methods_____

Height_____Weight_____Recent Weight Gain or Loss Yes No
Medications/vitamins and reasons on them: _____
_____
_____

Patient Name_____Date_____

Health History Intake #2

Systems Review: Have you had any problems or concerns with the following?

| | | | |
|---|---|---|---|
| Eye Problems | o Yes o No | Lung Problem | oYes o No |
| Ear Problems | o Yes o No | Digestive System | o Yes o No |
| Nose Problems | o Yes o No | Urinary System | o Yes o No |
| Throat Problems | o Yes o No | Bowel Problems | o Yes o No |
| Skin Problems | o Yes o No | Handicaps/Disabilities | o Yes o No |
| Heart Problems | o Yes o No | Musculoskeletal | o Yes o No |
| High Blood Pressure | o Yes o No | Headaches | o Yes o No |
| Back Pain | o Yes o No | Neck Pain | o Yes o No |
| Dizziness | o Yes o No | Extremity Pain | o Yes o No |

If you answered yes to any of the above conditions please go into further detail below including symptoms, dates, and frequency of the problems:

_____
_____
_____
_____
_____

How often do you exercise?_____
How would you describe your diet?_____
How much caffeine do you drink?_____
How much alcohol do you consume?_____
Do you smoke?_____How much?_____
Recreational Drug/Other chemical exposures_____
Do you have problems with Anxiety?_____Depression?_____
How often do you have headaches?_____
Please list any allergies_____
Hours of sleep to you typically get per night_____Position_____
Please list any major diagnosis/prior illnesses or surgeries_____
_____
_____

Females:
Are you pregnant?_____Date of last period_____
# past pregnancies_____# past births_____

I certify all the information provided is true to the best of my knowledge and consent to chiropractic care to treat the complaints listed above:
Patient Signature_____Date_____
Physician Signature_____Date_____