

## Confidential Patient Information

Name: \_\_\_\_\_ Hm Phone: \_\_\_\_\_ Wk/Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status (circle one) M S D W Age \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail Address \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City, St, Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Who may we thank for referring to our office? \_\_\_\_\_

Have you ever had Chiropractic care before? Yes  No  Date: \_\_\_\_\_

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Is this injury/illness related to: Automobile Accident  Other Type of Legal Action  N/A

Date/Time: \_\_\_\_\_ Location: \_\_\_\_\_

Your Auto Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Third Party Auto Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

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Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider, unless otherwise arranged. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you. Let us know if this is a problem and we will work to accommodate your needs.

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Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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**Why Chiropractic?** People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (*Relief Care*). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (*Corrective Care*). Your Doctor will weigh your needs and desires when recommending your treatment program.

### **RELIEF CARE**

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

### **CORRECTIVE CARE**

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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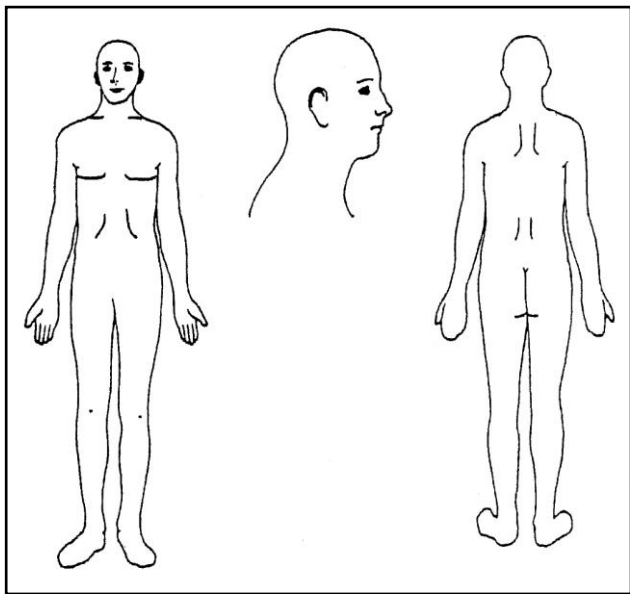
I authorize Mile High Chiropractic Center to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Authorizing Care: \_\_\_\_\_

## THANK YOU FOR ALLOWING US TO SERVE YOU!

**PLEASE MARK AN X ON THE DIAGRAM  
BELOW WHERE YOUR PROBLEMS ARE**



What hurts, How long has it hurt, When did it start?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please List All Medications You are Taking.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please List **ALL** Accidents, Trauma, or Surgeries.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**FAMILY HISTORY**

**M**other **F**ather **B**rother **S**ister

- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Heart troubles
- \_\_\_\_\_ Kidney Troubles
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Other Diseases (Please List Below)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Check any of the following you have. Mark with **C** for current or **P** for past:

- |   |  |
|---|--|
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Numbness                  |
| <input type="checkbox"/> Sinus Congestion/ Allergies  | <input type="checkbox"/> Frequent Nausea/ Vomiting |
| <input type="checkbox"/> Vision Problems              | <input type="checkbox"/> Abdominal Cramps          |
| <input type="checkbox"/> Ear Aches                    | <input type="checkbox"/> Constipation              |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Diarrhea                  |
| <input type="checkbox"/> Heart Problems               | <input type="checkbox"/> Poor / Excessive Appetite |
| <input type="checkbox"/> Lung Problems / Congestion   | <input type="checkbox"/> Excessive Thirst          |
| <input type="checkbox"/> Blood Pressure Problems      | <input type="checkbox"/> Painful / Excessive Urine |
| <input type="checkbox"/> Ankle Swelling               | <input type="checkbox"/> Discolored Urine          |
| <input type="checkbox"/> Prostate/ Sexual Dysfunction | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Menstrual Cycle Dysfunction  | <input type="checkbox"/> Cancer                    |

**Are You Pregnant?**     Yes     No     Not Sure



## Office Policies

The purpose of these agreements is to allow us to more completely serve you, and for you to receive the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

### SIGNING IN

When you arrive for your appointment, please sign in on touchscreen at the counter. If you are receiving a massage, please sign in.

### PAYMENT OF BILLS

You are expected to honor your financial agreements with our office. If you find that you cannot fulfill your agreement, please meet with our office manager immediately and make new arrangements. We are very flexible, but failure to be pro-active in addressing a problem, much like addressing your health problems, can result in a much bigger problem.

We have never turned a patient away because of inability to pay, but we have turned patients away for not making health a PRIORITY.

### PAYMENT AGREEMENTS

If you find your care is too costly, let us know and we will do our best to make every effort to accommodate your specific situation.

### MISSING OR CHANGING APPOINTMENTS

The doctor has established a specific course of treatment for you. For best results you need to receive a certain number of treatments within a set amount of time. We ask that you make up any missed appointments that week or the following week. If, for any reason you need to change an appointment, please call in two (2) hours prior to your appointment. We have set aside time to treat you, and by doing so, we are turning away other patients during your scheduled time. A \$35.00 fee will be assessed if you fail to notify us 2 hours prior to your scheduled appointment.

### CELL PHONES

We realize that cell phones are a part of our lives but we kindly ask that you **turn off** your phone before entering the office. Cell Phone signals may interfere with certain medical equipment in our office.

I have read and understand all of the above office policies and agree to them.

\_\_\_\_ Initials