

PATIENT INFORMATION SHEET

PATIENT

Last Name: _____ First Name: _____ MI: _____

Gender: M F Date of Birth: ____/____/____ SS# _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #: _____

Email Address: _____

SPOUSE or GUARDIAN

Last Name: _____ First Name: _____ MI: _____

Employer Name: _____ Work Phone #: _____

Date of Birth: ____/____/____ SS# _____

Relation to Patient: _____

METHOD OF PAYMENT

Insurance Company: _____

Personal Injury: YES NO If yes attorney name: _____

Workers Compensation: YES NO If yes claim number: _____

Non Insured: YES NO

Referred By: _____

Signature: (Patient, Parent, Legal Guardian or Responsible Party)

_____ Date: _____

If you have ever had a listed symptom in the past, please check that symptom in the past column. If you are presently troubled by a particular symptom, check that symptom in the Present column. Most manifestation code listings are provided for the doctor's reference.

PAST PRESENT

- Neck Pain (723.1)
- Shoulder Pain (719.41)
- Pain in Upper Arm or Elbow (719.42)
- Hand Pain (719.44)
- Upper Back Pain (724.1)
- Low Back Pain (724.2)
- Pain In Upper Leg or Hip (719.45)
- Pain in Lower Leg or Knee (729.5)
- Pain in Ankle or Foot (719.47)
- Jaw Pain (526.9)
- Swelling/Stiffness of Joint(s)
- Fainting, Visual Disturbances, Nausea (780.2)
- Convulsions (780.3)
- Dizziness (780.4)
- Headache (784.0)
- Muscular Incoordination (781.3)
- Tinnitus (Ear Noises) (388.30)
- Rapid Heart Beat (785.0)
- Chest Pains (788.50)
- Loss of Appetite (783.0)
- Abnormal Weight Gain (783.1)
 Loss (782.2)
- Excessive Thirst (783.6)
- Chronic Cough (786.2)
- Chronic Sinusitis (473.9)
- General Fatigue (780.7)

Present: Weight _____ pounds
Height _____ feet _____ inches

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

PAST PRESENT CONDITION

- Depression (311)
- Aortic Aneurysm (441.5)
- High Blood Pressure (401.9)
- Anolna (413.9)
- Heart Attack (410.9)
- Stroke (436)
- Asthma (493.9)
- Cancer (199.1)
- Prostate Problems (601.9)
- Anorexia (783.0)
- Blood Disorder (790.6)

PAST PRESENT

- Irregular Menstrual Flow (626.4)
- Profuse Menstrual Flow (626.7)
- Breast Soreness/Lumps (611.72)
- Vaginal Discharge (623.5)
- PMS (625.4)
- Loss of Bladder Control (788.30)
- Painful Urination (788.1)
- Frequent Urination (788.41)
- Abdominal Pain (789.0)
- Constipation/Irregular bowel habits (564.0)
- Difficulty in Swallowing (787.2)
- Heartburn/Indigestion (787.1)
- Dermatitis/Eczema/Rash (692.9)

Please check any of the following that apply to you.

- Tobacco Use (305.1)
- Alcohol Use (305.0)
- Birth Control Pills Used
- Medications (please list them) _____

- Drug or Alcohol Dependence (303.9)
- Pregnancy
- Surgical Procedures (please list them) _____

- Coffee/Tea/Caffeinated Soft Drinks, Cups Per Day: _____

PAST OR PRESENT HEALTH PROBLEM

FAMILY HISTORY:

Mother: _____
 Father: _____
 Brothers: No. of () _____
 Sisters: No. of () _____
 Patients Signature: _____ Date: _____

WAIVER FORM

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE EXACTLY WHAT THOSE GUIDELINES ARE. UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENT IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES, SUCH AS LAB WORK, MRI OR X-RAYS, THAT ARE NOT COVERED WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. PAYMENTS FOR THOSE CHARGES ARE THEN YOUR RESPONSIBILITY. AS THE POLICY HOLDER, ***YOU ARE RESPONSIBLE*** FOR KNOWING THE BENEFITS AND RESTRICTIONS OF YOUR INSURANCE COVERAGE.

I UNDERSTAND THAT SHOULD MY INSURANCE REQUIRE A ***REFERRAL/AUTHORIZATION*** PRIOR TO MY RECEIVING MEDICAL SERVICE AND I HAVE NOT OBTAINED THIS AND/OR THIS OFFICE HAS NOT RECEIVED THIS, ***I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.***

I UNDERSTAND THAT SHOULD IT BECOME NECESSARY TO PLACE MY ACCOUNT WITH AN OUTSIDE COLLECTION AGENCY THERE WILL BE AN ***ADDITIONAL 30% PENALTY*** ADDED TO MY DELINQUENT BALANCE.

THIS IS TO VERIFY THAT _____ WHOSE SIGNATURE IS AFFIXED BELOW, WAS INFORMED IN ADVANCE THAT ANY NON-COVERED SERVICE OR SERVICES DONE WITHOUT COVERAGE THROUGH INSURANCE WILL BE THE RESPONSIBILITY OF THE PATIENT.

THIS INCLUDES X-RAY CHARGES FOR MEDICARE PATIENTS, WHICH IS NOT COVERED IN A CHIROPRACTOR'S OFFICE.

ANY WORKMAN'S COMPENSATION CLAIM THAT IS DENIED WILL BE THE RESPONSIBILITY OF THE PATIENT.

ANY PERSONAL INJURY CLAIM THAT IS FILED THROUGH MEDICAL INSURANCE AND NOT PAID BY THE INSURANCE COMPANY WILL BECOME THE RESPONSIBILITY OF THE PATIENT.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE _____ DATE _____



Authorization For Chiropractic Treatment

I, the undersigned, a patient of this office hereby authorize the physician of Todd S. Elwert, D.C., Chiropractor, and whomever they may designate as their assistants, to administer such treatment as is necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization For Chiropractic Treatment, the reason why that above named treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the aforementioned physician.

I also certify that no guarantee or assurance has been made as to the results that may be attained.

Signed: _____ Date: _____



Attachment 3A
Patient Acknowledgment of Privacy Notice

To Be Maintained with Patient's Chart

This is to acknowledge that I (print name) _____
have been given the opportunity to review Todd S. Elwert, D.C., Inc. Privacy Practices and I
have been offered a copy of the notice.

Signature of Patient or Personal Representative

Date _____

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Todd S. Elwert, D.C., Inc. was unable to provide our Notice of Privacy and obtain an
acknowledgment signature for patient

Name: _____ because of the following reasons:

Staff Signature: _____ Date _____