Health History

Please complete this form using your keyboard, then print it using the print function of your browser. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Chiropractic Case History/Patient Information

Date Patient # **Doctor**

Name Social Security #

Address City

State Zip Home Phone

E-mail Fax # Cell Phone

Age Birth Date Race Marital: M S W D

# of children? Occupation Employer

Employer's Address Office Phone

Spouse Occupation Employer

Name of Nearest Relative Address

Phone How were you referred to our office?

Family Medical Doctor Purpose of this appointment

Date symptoms appeared or accident happened:

Have you ever had the same or a similar condition? ☐ Yes ☐ No

If yes, when and describe:

Days lost from work

Date of last physical examination

What surgeries have you had? (Include dates)

Serious illnesses (include dates)

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

If yes, describe:

What medications or drugs are you taking?

Please check any and all insurance coverage that may be applicable in this case.

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare

☐ Auto Accident ☐ Other

Name of Primary Insurance Company

Name of Secondary Insurance Company (if any)

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature Date

Guardian's Signature Authorizing Care Date

1. What is your major symptom?

2. If this is a recurrence, when was the first time you noticed this problem?

How did it originally occur?

Has it become worse recently? Yes No Same Better Gradually Worse

If yes, when and how?

3. How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All Day Few Hours Minutes

4. Are there any other conditions or symptoms that may be related to your major symptom?

Yes No If yes, describe

Are there other unrelated health problems?

Yes No If yes, describe

5. Describe the pain: Sharp Dull Numbness Tingling Aching

Burning Stabbing Other

6. Is there anything you can do to relieve the problem? Yes No

If yes, describe

If no, what have you tried to do that has not helped?

7. What makes the problem worse? Standing Sitting Lying Bending

Lifting Twisting Other

8. Have you had any broken bones? Yes No If yes, please list and give dates:

9. List any major accidents you have had other than those that might be mentioned above:

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes No If yes, please explain:

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes No Uncertain

12. Remarks:

Doctor’s Signature Date

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Dixon Chiropractic Clinic

Insurance Form

Please complete this form using your keyboard, then print it using the print function of your browser. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: ☐ Medicare ☐ Medicaid ☐ Champus ☐ CampVA ☐ Group Health Plan ☐ Other

Insured's ID Number _____

2. Patient Name: _____

3. Insured's Name (as it appears on the insurance card): _____
4. Patient's Address: _____

City _____ State _____ Zip _____ Phone Number _____

5. Insured's Address (if same as patient put "same"): _____

City _____ State _____ Zip _____ Phone Number _____

6. Patient Status: ☐ Single ☐ Married ☐ Other ☐ Employed ☐ Full-time Student ☐ Part-time Student

7. Other Insured's Name (if applicable): _____

Other Insured's Policy or Group Number: _____

Other Insured's Date of Birth: _____ ☐ Male ☐ Female

Employer's Name or School Name: _____

Insurance Plan Name or Program Name: _____

8. Is the condition we are treating related to current or previous employment? ☐ Yes ☐ No

9. Is the condition we are treating related to an auto accident? ☐ Yes ☐ No

10. Is the condition we are treating related to another type of accident? ☐ Yes ☐ No

11. Insured's Policy Group or FECA Number: _____

Insured's Date of Birth: ☐ Male ☐ Female

Employer Name or School Name:

Insurance Plan Name or Program Name:

12. Is there another health benefit plan? ☐ Yes ☐ No

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: Date:

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Dixon Chiropractic Clinic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: Date:

Medicare Only

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? ☐ Yes ☐ No

2. Are you entitled to Medicare because of End Stage Renal Disease? ☐ Yes ☐ No

3. Is the illness or injury the result of an accident or illness that occurred at work? ☐ Yes ☐ No

4. Is this illness or injury the result of an accident or other injury? ☐ Yes ☐ No

5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? ☐ Yes ☐ No

6. Are you entitled to any benefits under the Federal Black Lung Program? ☐ Yes ☐ No

7. Do you have a Medicare Medigap Policy? ☐ Yes ☐ No

8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? ☐ Yes ☐ No

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