Aldridge-Mead Chiropractic, Inc.
130 W. Main Street, Newark, OH 43055
(740) 345-8644 (p) ~ (740) 345-3325 (f)

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Major Accidents Past and Present: _____ When? _____

Serious Illness Past and Present: _____ When? _____

Infectious Diseases Past and Present: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Do you smoke? **Y / N** Amount _____ Do you drink alcoholic beverages **Y / N** Amount _____

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have a history of stroke or heart disease? _____

What is your stress level at work? (1 low – 10 high) _____ What is your stress level in your personal life? (1 low – 10 high) _____

Do you eat balanced meals? _____

Do you have a regular exercise program? _____

Family History: (Include things such as heart disease, diabetes, cancer, stroke and other debilitating diseases.) _____

_____

What is your goal in our office? _____

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse _____
Children _____
Other _____
No one _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? **Y / N**

_____ Date: _____
Patient / Guardian Signature

REVIEW OF SYSTEMS

Are you currently experiencing any of the following:

HEAD
_____headaches
_____trauma
_____dizziness
_____fainting
_____other_____

EYES
_____glasses
_____pain
_____spots
_____double vision/blurred
_____other_____

EARS
_____pain
_____ringing/noises
_____hearing loss
_____loss of balance
_____other_____

MENSRUAL/OBSTETRICAL
_____pregnant
_____menstrual cramps
_____breast tenderness/masses
_____difficult deliveries
_____other_____

NOSE AND SINUS
_____pain
_____nosebleeds
_____loss of smell
_____allergies
_____drainage
_____other_____

MOUTH AND THROAT
_____dentures
_____choking
_____gagging
_____sore throats
_____difficulty swallowing
_____other_____

NERVOUS SYSTEM
_____numbness
_____tingling
_____nervousness
_____coordination
_____convulsions
_____other_____

GENERAL HEALTH
_____addiction or substance abuse
_____HIV
_____other
_____
_____
_____

MUSCLES AND JOINTS
_____muscle pain
_____cramps
_____joint pain
_____joint swelling
_____joint stiffness
_____grinding/popping
_____other_____

GENITAL/URINARY
_____pain
_____difficulty urinating
_____night urination
_____blood/dark urine
_____bed-wetting
_____change in frequency
_____loss of bowel/bladder control

HEART AND LUNGS
_____asthma
_____chest pain
_____coughing
_____sputum
_____chest noises
_____difficult breathing
_____high blood pressure
_____other_____

STOMACH AND INTESTINES
_____pain
_____gas
_____burning
_____vomiting
_____constipation/diarrhea
_____hernia
_____appetite problems
_____other_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Aldridge-Mead Chiropractic, Inc. all medical benefits and/or insurance reimbursement (with the exception of Medicare), if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. 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 hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

ACKNOWLEDGEMENT OF PRIVACY POLICIES

I have read and fully understand the above statement. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

PRINT NAME:_____

SIGNATURE: _____ _____
Date

Aldridge-Mead Chiropractic, Inc.
130 W. Main Street
Newark, OH 43055
(740) 345-8644

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Aldridge-Mead Chiropractic, Inc.
130 W. Main Street
Newark, OH 43055

PAYMENT POLICY FOR _____ _____
Name Date

Visits to our office are payable when services are rendered. We accept checks, cash, Visa, and MasterCard.

WORKER'S COMPENSATION – This office DOES NOT participate in worker's compensation cases. Should you request care, it is to be understood that we will not submit paperwork to worker's compensation and **PAYMENT IS REQUIRED ON YOUR ACCOUNT**. Notify the front desk immediately if you were hurt at work.

PERSONAL INJURY/ AUTO ACCIDENTS - It is the policy of this office to file all claims through YOUR insurance company, regardless of who is at fault. If you have retained an attorney, notify us immediately so we can deal directly with him or her. PAYMENTS ON YOUR ACCOUNT ARE REQUIRED. A credit guarantee auto insurance assignment must be signed.

PRIVATE PAY – Payment is due when services are rendered. Payments at the time of service will receive a **TIME OF SERVICE DISCOUNT.**

HEALTH INSURANCE/MAJOR MEDICAL – Most insurance companies provide you with coverage for chiropractic care. **IT IS YOUR RESPOSIBILITY TO VERIFY YOUR COVERAGE WITH YOUR INSURANCE COMPANY.** There is no guarantee insurance will pay and you are ultimately responsible for payment of your account

MEDICARE – Our office does not accept Medicare assignment. We are required to file your Medicare. Payment is due at time of service. Medicare payments will be mailed directly to you. Therefore, payment on your account is required. **THERE IS NO GUARANTEE MEDICARE WILL COVER OR PAY FOR CHIROPRACTIC SERVICE.**

MEDICAID – This office does not participate in Medicaid programs.

You are responsible for any fees, legal or otherwise, incurred in collecting payment of your account should it become past due.

TO AVOID A $20.00 MISSED APPOINTMENT FEE, YOU MUST CALL PRIOR TO YOUR SCHEDULED TIME WHEN YOU ARE UNABLE TO KEEP ANY APPOINTMENT.

Signed_____ Date _____

Witness_____ Date_____