



CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address: _____

Please Check Type of Payment: Cash Check MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____ Your SS#: _____

Do You Have Health Insurance? Yes No Insurance Company: _____

Insurance Plan/Group#: _____ Your Work Hours: _____

Do You Have Medicare? Yes No Medicaid? Yes No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer: _____ Occupation: _____

Office Phone: _____ Cell Phone: _____ Spouse's SS#: _____

Describe The Major Complaints That Bring You To Our Office: _____

Is Your Condition Due To An Accident? Yes No Date of Accident: _____

Type of Accident? Auto Work/Job At Home Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____ Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.



HEALTH REVIEW

Please Check All Present Symptoms:

Skin, Hair, Nails

- Eczema
- Itchy skin
- Rough, scaly skin
- Dry skin
- Oily skin
- Yellow skin
- Bruise easily
- Baldness
- Paper thin nails
- Nail biting

Eyes

- Blurred vision
- Double vision
- Eye fatigue
- Excessive tearing
- Lack of tearing
- Light bothers eyes
- Excessive itching
- Pain in eyeball

Ears

- Loss of hearing
- Not sufficient
- Pain in ears
- Discharge from ears
- Vertigo
- Ringing in ears

Nose & Sinuses

- Nose bleeds
- Pressure over eyes
- Nose obstruction
- Frequent colds
- Sinusitis
- Loss of smell
- Allergies

Mouth & Throat

- Pain in throat
- Bleeding gums
- Abscessed teeth
- Dentures
- Difficulty swallowing

Respiratory

- Shortness of breath
- Dry cough
- Coughing up blood
- Wheezing
- Productive cough

Gastrointestinal

- Poor appetite
- Constant nibbling
- Difficulty swallowing
- Indigestion
- Nausea & vomiting
- Abdominal pain
- Change in bowel habits
- Diarrhea
- Constipation
- Hemorrhoids

Genitourinary

Urination is

- Frequent
- Not sufficient

The amount is

- High
- Moderate
- Low
- Frequent urination at night
- Intense desire to urinate
- Difficulty urinating
- Lack of control
- Pain with urination
- Dribbling
- Bloody urine
- Cloudy urine

Venereal Disease

- Syphilis
- Gonorrhea
- Other

Women Only

- painful periods
- spotting
- premenstrual symptoms
- irregular periods
- lumps in breast
- vaginal discharge
- # of pregnancies _____
- # of deliveries _____

Social History

- Smoking
- Other tobacco use
- Alcohol use
- Drink coffee or tea

Diet is

- Balanced
- Not balanced

Rest is

- Sufficient
- Not sufficient

Recreation is

- Sufficient
- Not sufficient

Family stress is

- Severe
- High
- Moderate
- Minimal
- None

My job stress is

- Severe
- Moderate
- Minimal
- None

- Nervousness
- Irritability
- Fatigue
- Depression
- Panic attacks
- Problems sleeping
- Generally feel run-down



MUSCULOSKELETAL SYSTEM

Please Check All Present Symptoms:

Head

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Dizziness
- Light headedness
- Loss of taste
- Loss of smell
- Loss of hearing
- Loss of balance

Neck

- Pain in neck
- Pain with movement
- Swelling in neck
- Stiffness in neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

Mid-Back

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms

Lower Back

- Lower back pain
- Lower back feels out of place
- Muscle spasms

Shoulders

- Pain in shoulders
- Pain across shoulders
- Muscle spasms
- Can't raise arm
- Above shoulder
- Above head

Arms & Hands

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pins & needles
- In arms
- In fingers
- Fingers go to sleep
- Cold hands
- Swollen fingers
- Loss of grip strength

Hips, Legs & Feet

- Pain in buttocks
- Pain in hip
- Pain down leg
- Knee pain
- Leg cramps
- Pins & needles in legs
- Numbness in legs
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen feet



HEALTH HISTORY

Name: _____ Date: _____

List All Current Health Problems:

List Any Other Doctors Seen, Treatments And Results Obtained:

Your Current Physician(s)/Therapist(s):

List All Surgeries And Their Dates:

List Any Medications You Are Taking:

List Any Traumas And Their Dates:

Please Check The Conditions You Have Or Have Had:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease | |

Please Check All Present Symptoms:

CARDIOVASCULAR

- General swelling
- Swelling in legs
- Swelling in face
- Swelling around eyes
- Chest pain
- Pounding heart beat
- Rapid heart beat
- Irregular heart beat
- Blue or purple skin
- Blue or purple nail beds
- Cold hand/feet

VERTEBROBASILAR

- Double vision
- Loss of coordination
- Loss of memory
- Ringing in ears
- Heart attack
- High blood pressure
- Muscle weakness
- Dizziness
- Blurred vision
- Stroke
- Hypertension
- Inability to form words
- Burning sensations
- Blindness
- Previous head injury
- Previous neck injury
- Taking birth control pills
- Family history of stroke
- Blood vessel disease
- Check if you smoke
- Fainting
- Area of numbness



CONFIDENTIAL PATIENT INFORMATION (BACK)

This section is be filled out by the doctor only

Name: _____ **Date:** _____ **File#:** _____

Date of onset: _____

Dates of similar symptoms: _____

Course: S B W

Condition is related to patient's: () Work () Auto () other accident

1. **Onset: (how)**

Medical treatment:

Results?:

2. **Onset: (how)**

Medical treatment:

Results?:

3. **Onset: (how)**

Medical treatment:

Results?

Complications: Surgeries:

History of accidents: D.C. History:

Any activities limited: Medications:

ANYTHING ELSE WE NEED TO KNOW TO HELP US TO HELP YOU?



FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).
5. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient, it is your responsibility to take care of the co-payment (usually 20%) and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.
8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.
11. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
12. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
13. If you change insurance companies or employers, you agree to provide this office with current information immediately.
14. This office accepts, Mastercard, Visa, Cash and Personal Checks.
15. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient Signature

Date



TERMS OF ACCEPTANCE

When a patient seeks Upper Cervical health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Upper Cervical care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Correction: An upper cervical correction is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments to the upper cervical spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. However, if during the course of an upper cervical examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)



PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Upper Cervical Health Centers Of America may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Health Centers of America Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCHCA reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UCHCA.

With my consent, UCHCA may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, UCHCA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Upper Cervical Health Centers of America's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Upper Cervical Health Centers Of America may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature

Date

Authorization to Pay/Release Is Granted to:

Upper Cervical Health Centers Of America