

Patient Entrance Form

Please Note: Our new extensive entrance form is necessary for compliance with the Health Care Financing Administration and the National Committee for Quality Assurance's new standards. Please fill it out completely.

Name _____ Phone () _____ Cell Phone () _____

Address _____ City _____ State _____ Zipcode _____

Age _____ Birthdate ____/____/____ Gender: M / F No. Children _____ Social Security # _____

Marital Status: Single Married Widowed Separated Divorced Student

Email address _____ How did you hear about us? _____

Occupation _____ Employer _____ Work Phone () _____

Employer Address _____ City _____ State _____ Zipcode _____

Spouse Name _____ Birthdate ____/____/____ Social Security # _____

Occupation _____ Employer _____ Work Phone () _____

Emergency Contact _____ Phone () _____ Relationship _____

Patient's Primary Care Physician (PCP) _____ Phone () _____

Date of Last Physical Exam _____ Referred by: _____ Email _____

Please describe your current problem _____

Is your current problem the result of: Auto Accident? Yes No Slip & Fall? Yes No

Work Place injuries are accepted on a case-by-case basis only. Is this a Work Place injury? Yes No

How did your problem begin _____

Date Problem began _____ Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? Yes No If yes, please explain:

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Burning Throbbing Shooting Tingling Gripping
 Dull Numbness Soreness Aches Weakness Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem better? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

What makes the problem worse? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

Can you perform your daily home activities: Yes Only with help Not at all

Do you exercise? Yes, almost daily Yes, occasionally Not at all

Describe your job requirements: Mainly Sitting Light Labor Heavy Labor

Can you perform your daily work activities: Yes, all activities Only some Not at all

Describe your stress level: None to mild Moderate High

SCHULZE FAMILY CHIROPRACTIC
Patient Health Questionnaire

Patient Name _____

Acct# _____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancies |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling, Stiffness of Joints |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vision Disturbances |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pain - Neck | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Pain - Mid Back | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pain - Low Back | Height: _____ feet _____ inches |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pain - Arm/Elbow | Weight: _____ pounds |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain - Hand | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pain - Wrist | |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain - Ankle or Foot | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain - Leg | <u>For all patients over 13 yrs. old:</u> |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pain - Knee | <input type="checkbox"/> Smoking - Packs/Day _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> PMS | <input type="checkbox"/> Alcohol - Drinks/Week _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Coffee/Caffeine Drinks - Cups/Day _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Alcohol Dependence |
| | | <input type="checkbox"/> Drug Dependence |

Please list all allergies including allergies to medications _____

List all medications you are presently taking (including vitamins & supplements)

List any surgeries, fractures, serious illnesses or hospitalizations _____

In an emergency would you want CPR? Yes No

In an emergency would you want life support? Yes No

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

- | | | | | |
|-------------------------------------|-----------------------------------|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | Other _____ | | | |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

SCHULZE FAMILY CHIROPRACTIC
Patient Insurance Information

Patient Name _____

Acct# _____

Please Note: We need to copy your insurance identification card for your file.

A. Subscriber Information: (Please complete A & B, if other than patient or lives at different address)

Subscriber Name _____ Birthdate ____/____/____ Phone (____) _____

Address _____ City _____ State _____ Zipcode _____

Relationship to patient _____ Subscriber's Social Security # _____

Employer Name _____ Work Phone (____) _____

Insurance Co. Name _____ Ins Co. Phone (____) _____

Insured's ID # _____ Group # _____

Is patient covered under any other insurance? Yes No If yes, please complete the following:

B. Second Insurance:

Subscriber Name _____ Birthdate ____/____/____ Phone (____) _____

Address _____ City _____ State _____ Zip code _____

Relationship to patient _____ Subscriber's Social Security # _____

Insured's Employer _____ Work Phone (____) _____

Insurance Co. Name _____ Ins Co. Phone (____) _____

Insured's ID # _____ Group # _____

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION, AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Schulze all insurance benefits, if any, otherwise payable to me for the services rendered. If enrolled with an HMO and without the appropriate referral or authorization from my Primary Care Physician, I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Schulze to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as valid as the original.

Patient or Guardian Signature _____ Date _____

OPEN TREATMENT ROOM NOTICE

I am aware of and in acceptance of receiving chiropractic services in an Open Treatment Environment. All personal information will be discussed in a private room, however. This is designed to reduce patient time spent in office and increase the efficiency of the office. A private treatment room is available on a limited basis if requested. This room is for occasional use only and not meant to be used for every treatment.

Date: _____ Name of Patient (print) _____

Signature of Patient/Personal Representative _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Schulze Family Chiropractic's Notice of Privacy Practices for protected health information. (Please see Privacy Notice posted on waiting room wall.)

Date: _____ Name of Patient (print) _____

Signature of Patient/Personal Representative _____

PATIENT COMMUNICATION AUTHORIZATION

Dr. Schulze and members of his staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. This contact could also be made through the mail on a postcard, and if you have referred someone to our office we need your authorization to use your name (First Name and Last Initial) on our Honor Roll Board in the office waiting room. By signing this form, you are giving us authorization to contact you with these reminders and information and to use your name (First Name and Last Initial) on our Honor Roll Board in the waiting room.

PLEASE REVIEW AND ASK ANY QUESTIONS BEFORE SIGNING.

Patient or Guardian Signature _____ Date _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _____ Date _____

ASSIGNMENT, RECORDS RELEASE, AND PAYMENT AGREEMENT

THIS AGREEMENT, entered into this date by and between _____ hereinafter called "Patient", and Schulze Family Chiropractic, hereinafter called "Provider". WHEREAS Patient desires to receive health care services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

1. Patient assigns to Provider any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to the following described policies or plans:

This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by Patient for services rendered by Provider. The total amount paid to Provider from all sources shall not exceed the total amount of Provider's billings for services. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of Patient's assignment of benefits is a convenience to Patient, and that Provider may revoke this assignment at any time.

2. Patient hereby directs all insurers and other persons responsible for Patient's health care costs to make all payments for health care services rendered by Provider directly to Provider.

3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

4. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this Agreement, Patient will act as fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft, or payments to Patient's debt for services rendered.

5. Patient hereby authorizes Provider to release and permit the examination and/or copying of any of Patient's medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such persons as Provider deems appropriate.

6. A copy of this document shall be as binding as the document bearing original signatures.

7. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or health care plan. Patient further agrees to pay for any services not covered by Patient's insurance or health care plan.

8. In the event that any Section or provision of this Agreement is legally void, invalid, or unenforceable, all other Sections and provision of this Agreement shall remain in full force and effect.

9. The assignments and agreements contained in this document may not be revoked by Patient without the express written consent of the Provider.

10. In the event of any default in the performance of this Assignment, all amounts due Provider shall become immediately due and payable and Patient agrees to pay all costs of collection and attorneys fees incurred by Provider in any arbitration or litigation which shall arise there from. From and after the date of any such breach, the amount due Provider shall bear interest at the rate of 10% per annum.

I (we) hereby authorize Schulze Family Chiropractic to obtain and access any and all information from insurers, health plans, third party payers or attorneys related to charges, payments and settlements for services rendered to me. IN WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

Patient

Date