Schaffer Chiropractic New Patient Form

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Confidential Patient Information:

Name_____ Today's Date_____

Address_____City_____State_____

Zip_____ Home Phone_____ Work Phone_____

Cell Phone _____ Date of Birth _____ Age_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security No_____ Email Address_____

Employer_____

Occupation_____

In Case of Emergency Contact:

Name_____ Phone_____

REFERRED BY: ☐ Clipper ☐ Trib ☐ Friend/Family:_____ ☐ Other:_____

Symptom / Pain Information:

1. Reason for this appointment:_____

2. Describe the character of your symptoms (burning, tingling, aching, numbness, sharp, dull, shooting, radiating, etc.)_____

_____

3. What aggravates your symptoms? (Sitting, standing, bending forward/backwards, etc.)_____

_____

4. Please mark on the scale how severe your discomfort has been recently: (0 = no discomfort / 10 = worst possible discomfort) 1 2 3 4 5 6 7 8 9 10

5. How many episodes have you had similar to this in the past?

☐ None ☐ 1-5 Episodes ☐ 6-10 Episodes ☐ One single episode of continuous pain

6. What do you hope to do better or enjoy more when you regain your health?

_____

7. Other Doctors seen for this condition? _____

8. Have you ever suffered from any of the following? (Check all that apply)

☐ Arteriosclerosis ☐ Carpal Tunnel Syndrome ☐ Multiple Sclerosis ☐ Asthma
☐ Double/Blurred Vision ☐ Stroke ☐ Arthritis ☐ Epilepsy ☐ Ear Infections
☐ Cancer ☐ High Blood Pressure ☐ Allergies ☐ Diabetes ☐ Migraines
☐ Fatigue (chronic) ☐ Dizziness/Fainting ☐ Back Surgery ☐ Low Blood Pressure
☐ Anemia ☐ Digestive Disorders ☐ Sinus Trouble ☐ HIV Infections
☐ Thyroid Problems ☐ Broken Bones ☐ Tuberculosis ☐ Depression ☐ Appendicitis

9. Remarks and/or additional information:_____

Payment / Insurance Information: Are you insured? ☐ Yes ☐ No

Insurance Carrier _____ ID Number _____

Group Number _____

Subscriber's Name on the above policy_____

Date of Birth_____

This policy is through the subscriber's employment? ☐ Yes ☐ No

Employer:_____

Address:_____

Patient's relationship to the subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
If "Other, please specify relationship to the subscriber: _____

WORK RELATED INJURY Employer's insurance carrier_____

Adjuster_____

Address_____

Phone # _____

Do you have authorization from the company or a panel physician for chiropractic treatment ☐ Yes ☐ No Please provide a copy of this documentation prior to treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I have been of my above benefits, limits, co-pays and deductibles.. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. 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.

Date:_____ Patient's Signature:_____

Date:_____ Guardian Signature:_____

OFFICE USE ONLY

Verified Benefits ☐ Navinet ☐ By Phone – spoke with _____
Annual Deductible $_____ Benefit Maximum per year $_____
Lifetime $_____ Maximum # of Visits per Year _____
Applicable to ☐ Manipulations ☐ Therapies ☐ Office Visits Co-pay for Chiropractic Visits $_____ ☐ per visit ☐ per treatment