Biss Clinic of Chiropractic

New Patient Form - General Information

Last Name: _____ First Name: _____ MI: _____ Date: _____

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

Social Security #: _____-_____-_____ E-mail Address: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell: (_____)_____

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____

Occupation: _____ Employer: _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Provider: _____ Group Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber's Name: _____

Birthdate: _____ Social Security #: _____-_____-_____

Relationship to patient: _____

Insurance Provider: _____ Group Number: _____

AGREEMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Patient Conditions and Symptoms

Major Pain or Problem: _____

When did the pain/problem start? _____

Is the pain/problem due to an accident? ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Other

Attorney Name (if applicable): _____

Rate the Pain:

No Pain 0 - - - - - 1 - - - - - 2 - - - - - 3 - - - - - 4 - - - - - 5 - - - - - 6 - - - - - 7 - - - - - 8 - - - - - 9 - - - - - 10 **Extreme Pain**

Describe the pain? ☐ Sharp ☐ Dull ☐ Intermittent ☐ Constant Frequency: _____

What activities aggravate the pain? _____

What activities ease the pain? _____

Does the pain get worse at certain times of the day? ☐ Yes ☐ No When? _____

Does the pain interfere with work? ☐ Yes ☐ No Sleep? ☐ Yes ☐ No Other? ☐ Yes ☐ No _____

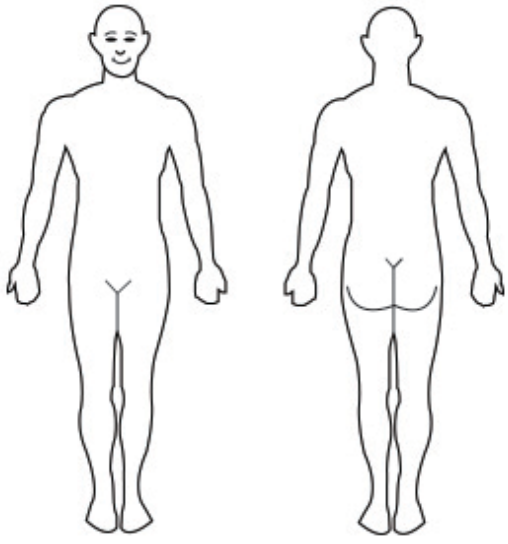
Is the pain getting worse? ☐ Yes ☐ No

Other Symptoms:

☐ Headaches	☐ Neck Pain	☐ Back Pain	☐ Chest Pain	☐ Dizziness
☐ Tension	☐ Stiff Neck	☐ Irritability	☐ Aching	☐ Fatigue
☐ Fainting	☐ Upset Stomach	☐ Numbness	☐ Swelling	☐ Tingling

Other: _____

Mark an X on the picture below where you continue to have pain, numbness, and/or tingling.



Health History

What treatment have you received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of Last:

Physical Exam: _____ Chest X-Ray: _____ Blood Test: _____

Spinal Exam: _____ Spinal X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	**Goiter**	☐ Yes ☐ No	**Pinched Nerve**	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	**Gonorrhea**	☐ Yes ☐ No	**Pneumonia**	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	**Gout**	☐ Yes ☐ No	**Polio**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	**Prostate Problem**	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	**Hepatitis**	☐ Yes ☐ No	**Prosthesis**	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	**Hernia**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	**Herniated Disk**	☐ Yes ☐ No	**Rheumatoid Arthritis**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Herpes**	☐ Yes ☐ No	**Rheumatic Fever**	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Scarlet Fever**	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	**High Cholesterol**	☐ Yes ☐ No	**Sexually Transmitted Disease**	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	**Kidney Disease**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	**Liver Disease**	☐ Yes ☐ No	**Suicide Attempt**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Measles**	☐ Yes ☐ No	**Thyroid Problems**	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	**Migraine Headaches**	☐ Yes ☐ No	**Tonsillitis**	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	**Miscarriage**	☐ Yes ☐ No	**Tuberculosis**	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	**Mononucleosis**	☐ Yes ☐ No	**Tumors, Growths**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Multiple Sclerosis**	☐ Yes ☐ No	**Typhoid Fever**	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	**Mumps**	☐ Yes ☐ No	**Ulcers**	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No	**Vaginal Infection**	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	**Pacemaker**	☐ Yes ☐ No	**Whooping Cough**	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	**Parkinson's Disease**	☐ Yes ☐ No	**Are You Pregnant?**	☐ Yes ☐ No

Other: _____

Health History (cont.)

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS:

☐ Smoking Packs/Day: _____

☐ Alcohol Drinks/Week: _____

☐ Coffee/Caffeine Drinks Cups/Day: _____

☐ High Stress Level Reason: _____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all 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.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's / Guardian's Signature: _____ Date: _____