PLEASE PRINT

What is your major complaint? _____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition _____

_____

What do you believe is wrong with you? _____

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others _____

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	
DO YOU:			
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

_____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS _____ PHONE _____

Our Office Policy

We welcome you to our office and assure you that you will receive the very best of care available.

The fees charged in our office are comparable to those charged by other health care providers in this area, with similar qualifications.

Health and accident policies are an arrangement between you and your insurance company. All services will be charged directly to you and you will be personally responsible for payment.

For Patients with No Insurance

It is customary to pay for professional services when rendered. We ask that you pay for your visit the same day.

For patients Injured on The Job (Workers Compensation)

Your employer is responsible for any costs in treating your symptoms relating to your work injury. If your injury is work related be sure to tell us before starting treatments. Your work injury must be reported to your employer.

For patients with Insurance

As a courtesy we will accept your insurance assignment, as soon as the responsible party verifies your coverage. We will file your claim forms and assist you in every way we can.

Auto Accident/Personal Injury

If you were involved in an auto accident, we will bill the medical insurance portion of the insurance policy of the vehicle in which you were riding. If you are the owner of the vehicle, we will bill your own insurance.

If you were a passenger in someone else's car, we will bill the drivers' insurance company. If you were a passenger in a vehicle, which was not insured, but you own a car, which has medical coverage, the insurance company, which carries your policy, will be responsible for your medical bills.

Missed/cancelled appointments without 24-hour notice will be charged.

If you are using a lien for a car accident, full cooperation and compliance is expected to insure the most effective healing for you. **You will be expected to pay your balance if you neglect your treatments or if you stop care for greater than 21 days,** unless previously arranged by our office.

If you were involved in a slip and fall type injury, we will bill the responsible party and your attorney.

Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it. If you discontinue care without authorization the balance of your account is due and payable in full immediately, even if your insurance has been filed.

Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.

We will bill your insurance on 30-day cycles as long as you are receiving care in this office.

You should pay the percentage of your responsibility the day of the visit, (e.g. if your insurance pays 80% of your care, you should pay 20% on each visit).

You will be required to sign an "Authorization to Pay" form and any other assignment or lien forms required by your insurance company on your first visit.

Our office will NOT enter a dispute with your insurance company over your claim. This is your responsibility and obligation.

We ask that you please notify us within 24 Hours in advance if you cannot keep your appointment. Missed appointments will be charged to you at half the amount. It is very important to keep your appointments to maintain your health and wellness.

If you have any questions, please feel free to discuss them with us.

FINANCIAL AGREEMENT

I am receiving (or about to receive) health care services at Eureka Square Chiropractic and I understand that I am directly responsible for all my health care bills submitted by this office for the services rendered.

This agreement is made solely for the providers' protection in consideration of having to wait for payment for these services, providing that there continues to be a reasonable probability that payment will be made either by insurance proceeds or out of the settlement of a liability.

I have read and fully understand my responsibility concerning the payment of services rendered.

Patient Signature: _____

Date Signed: _____

Witness Signature: _____

Thank you for coming to our office here at Eureka Square Chiropractic, we look forward to providing you with the best service we can. You and your health needs are our chief interest and concern.

Welcome
To

Eureka Square Chiropractic

Our Office Policy
Financial Arrangements