ACCT#_____ PATIENT INFORMATION PG. 1

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO BETTER SERVE YOU. PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT.

Full Name_____ Sex: M F

Home Phone_____ Cell Phone _____ Work Phone _____

Address_____ City_____ State_____ Zip Code_____

Age_____ Birth Date_____ Marital Status (Circle One) S M W D Sep Number of Children_____

SSN#_____-_____-_____ Driver's License Number_____

Email Address _____

Employer_____ Occupation _____ Number of Years _____

Employer Address_____ City_____ State_____ Zip Code_____

Name of Spouse/Subscriber _____Spouse/Subscriber Date of Birth: _____

Do you have Health Insurance? Yes___ No___ Are you the subscriber? Yes ___ No ___

Insurance Company_____ Subscriber ID#_____ Plan/Group #_____

In Case of Emergency:

Name of Spouse, Parent, or Guardian_____

Spouse's Employer_____ Spouse's Work Phone_____

Employer's Address_____ City _____ State_____ Zip Code_____

How did you find out about our office? _____

Is your condition today due to an accident? Yes___ No___ Date of Accident_____

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

I (We) authorize the doctor and his staff to release any information deemed appropriated concerning my physical condition to any ins. Co. attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a Photostatic copy of this agreement shall serve as the original.

I (We) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a Photostatic copy of this agreement shall serve as the original.

**Patient Signature_____Date_____**

**Spouse or Guardian Signature_____Date_____**

1. Notice to our new patients: Full payment for services rendered is due at the end of each visit.
2. Insurance cases: We gladly accept insurance assignment if your insurance co. a) verifies the deductible has been met, b) provides details of your coverage, and c) agrees to make payment directly to our office.
3. We file your primary ins. at no charge to you. Filings for policies in addition to you primary coverage for a fee and as time permits.

THANK YOU!

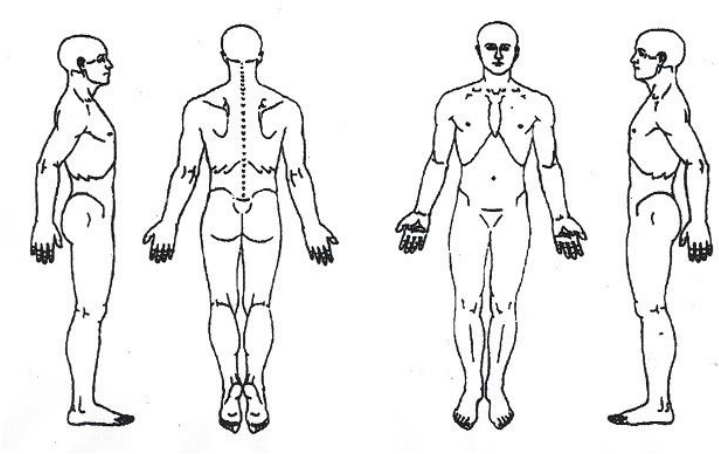
Name_____ Age_____ Sex: M F Date_____

What brings you into our office today? (Please Explain)_____

DETAILS OF THE CHIEF COMPLAINT:

1. Location of Symptoms, Injury, or Pain:

**Using adjacent body charts, please circle all the affected areas.**



Order of Appearance or Injury (Area)

1._____ 2._____ 3._____

Intensity of Pain (0= no pain, 10= worst)

1._____ 2._____ 3._____

(AMA Pain Scale: Minimal 1-3, Slight 4-6, Moderate 7-9, Emergency 10)

2. Has your pain spread or radiated anywhere? Yes__ No__

If so where?_____

3. When and how did it start?_____

_____

Date of Occurrence:_____ Date of First Visit_____

4. How would you describe your pain? (Sharp, Dull, Achy, etc.)

_____

5. How often do you experience your problem? (% of day)

__ Intermit. 0-25% __Occas. 26-50% __Frequent 51-75% __Constant 76-100%

6. What aggravates your condition? (posture, activity, etc)_____

_____

7. Is this an aggravation of an old injury? Y___ N___

Have you experienced anything similar to this in the past?_____

8. Have your symptoms changed since onset? Y___ N___

Decreased___ Increased___ Remained the same___ Come and Go___

9. Have you noticed any change in bodily functions? Y___ N___ (Please check those that apply.)

| | | | |
|---|---|---|---|
| ___ Balance | ___ Bowel Habits | ___Breathing | ___Coordination |
| ___ Coughing | ___Walking | ___Grip Strength | ___Hearing |
| ___ Menstrual | ___Sexual | ___Sleep | ___Sneezing |
| ___ Urination | ___Vision | ___Weakness | ___Weight |

10. Handedness: Right____ Left____ Ambidextrous____

11. Are there any activities that are harder to do or that you cannot do as a result of your condition?_____

_____

12. Work Status: Full Time___ Part Time___ Student____ Retired_____ Disabled____ Unemployed___

13. Work/Home Disability: Y__ N__

Complete: ___Days off work

___Days unable to perform Household tasks

Partial: ___Days of job modification

___Days of decreased household tasks

14. Have you used any Store-bought or Home Remedies? Y__ N__

If so what? _____

Did they help? _____ Have you tried Ice? ___ or Heat?___

15. Are you able to find relief with certain activities, postures, time of the day, etc? Y__ N__

If so, please explain._____

16. Have you been treated by anyone else for this problem? Y__ N__

If so, please identify who and what type of therapy? _____

17. Are you currently under a doctor's care for any <u>other</u> conditions? Y__ N__ If so, please explain.

_____

18. Have you suffered any physical injuries such as falls or blows, whiplash, concussion, or head injury, lacerations, sprains, strain, dislocations, broken or cracked bones? Y__ N__

Please explain._____

19. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

_____Date_____

_____Date_____

_____Date_____

_____Date_____

20. Have you ever been hospitalized for any reason other than surgery? Y__ N__

21. Do you have a Pacemaker or any other Surgically Implanted Device? Y__ N__

22. Are you now or could you be pregnant? Y__ N__ Onset date of last menstrual cycle._____

23. Females, have you had menstrual problems? Y__ N__ Explain_____

Have you ever taken birth control pills? Y__ N__ If so, for how long?_____

24. Do you have any nervous system diseases and/or mental health problems? Y__ N__

_____

25. Do you have any muscle, tendon, or ligament problems? Y__ N__

26. Do you have any bone or joint diseases (ex. Bone= Osteoporosis, Joint= Arthritis)? Y__ N__

27. Do you have any gland or hormone problems? Y__ N__

28. Have you ever had cancer? Y__ N__

29. Are you losing weight without trying? Y__ N__

30. Does your pain wake you up at night? Y__ N__

31. Have you had any change in bowel or bladder habits? Y__ N__

32. Have you had a sore that does not heal? Y__ N__

33. Have you recently had any unusual bleeding or discharge? Y__ N__

34. **Medications:** Please list all medications (prescriptions and non-prescriptions) you are currently taking or take on an occasional basis:

| Name of Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

35. Do you have any allergies to medications? Y__ N__ If so, what? _____
36. Do you consume alcohol? Y__ N__ If so, how much? _____ How often? _____
37. Do you use drugs? Y__ N__ If so, what? _____
38. Do you currently smoke? Y__ N__ How much per day?_____ # of Years_____
    Former smoker? Y__ N __ How many years did you smoke?_____ How many years smoke free?_____
39. Please describe the postures and/or positions in which you work, as well as the type of work you do:_____

_____

_____

40. In what position do you usually sleep, and how well? _____
41. Family History-Parents still living? Y__ N__ Age(s)_____ Parents deceased? Y__N__ What age(s)?___
    Any diseases or medical conditions for any family members? If yes, please explain relationship and condition._____

_____

_____

Miscellaneous Notes_____

_____

_____

_____

_____

Doctor Notes:

_____

_____

_____

_____

_____

Name_____ Age_____ Date_____ File#_____

Have you ever (at any time) experienced any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Difficulty urinating | Y | N | Claustrophobia | Y | N |
| Loss of bladder control | Y | N | Spinal surgery | Y | N |
| Loss of bowel control | Y | N | Common cold/flu | Y | N |
| Temporary loss of vision, one eye | Y | N | Carotid artery surgery | Y | N |
| Blood in urine | Y | N | Breast reduction | Y | N |

Have you ever been diagnosed with or told you have one of the following?

| | | | | | |
|---|---|---|---|---|---|
| Detached retina | Y | N | Rheumatoid Arthritis | Y | N |
| Stroke | Y | N | Fractured/broken vertebra | Y | N |
| Slipped disc | Y | N | Bleeding disorders | Y | N |
| Herniated disc | Y | N | High blood pressure | Y | N |
| Osteoporosis | Y | N | Blood in the stool | Y | N |
| TIA's (pin or mini strokes) | Y | N | Cancer | Y | N |
| Drop attacks (collapsing) | Y | N | AIDS | Y | N |
| Hardening of the arteries | Y | N | Kidney disease | Y | N |
| Partial or complete paralysis | Y | N | Prostate disease | Y | N |
| Diabetes | Y | N | | | |

In the past 14 days (2 weeks), have you experienced any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Nausea | Y | N | Vomiting | Y | N |
| Vertigo (spinning) | Y | N | Difficulty Walking | Y | N |
| Incoordination | Y | N | Numbness or other sensory change | Y | N |
| Loss of consciousness | Y | N | Double Vision | Y | N |
| Tinnitus (ringing in ears) | Y | N | Blurred Vision | Y | N |
| Speech problems | Y | N | Clumsiness | Y | N |
| Memory loss | Y | N | Personality changes | Y | N |
| Fever | Y | N | Recurrent headaches | Y | N |
| Diarrhea | Y | N | A Major Fall | Y | N |
| Skin rash/infection | Y | N | A Minor Fall | Y | N |
| Loss of strength | Y | N | An Auto accident | Y | N |
| Pain moving bowels | Y | N | A work injury | Y | N |
| Abnormal periods | Y | N | Head Trauma | Y | N |

Do you *Currently* have any of the following?

Integument System

| | | |
|---|---|---|
| Skin rash | Y | N |
| Skin lesions | Y | N |
| Changes in skin color | Y | N |
| Itching (pruitus) | Y | N |
| Hair changes | Y | N |
| Nail Changes | Y | N |

Endocrine System

| | | |
|---|---|---|
| Hormone problems | Y | N |
| Hot flashes | Y | N |
| Thyroid problems | Y | N |
| Hormone therapy | Y | N |
| Growth abnormalities | Y | N |
| Metabolism changes | Y | N |

Digestive System

| | | | | | |
|---|---|---|---|---|---|
| Abdominal pain | Y | N | Rectal bleeding | Y | N |
| Nausea | Y | N | Jaundice | Y | N |
| Vomiting | Y | N | Abdominal distention | Y | N |
| Constipation | Y | N | Cramping | Y | N |
| Diarrhea | Y | N | Lump/mass | Y | N |

(Please continue on the next page.)

## Cardiovascular System

| | | | | | |
|---|---|---|---|---|---|
| Chest pain | Y | N | Changes in skin color | Y | N |
| Irregular heartbeat | Y | N | Stroke | Y | N |
| Shortness of breath | Y | N | Dizziness | Y | N |
| Fainting | Y | N | Cool hands or feet | Y | N |
| Fatigue | Y | N | Varicose veins | Y | N |
| Swelling in the legs | Y | N | Pin Stroke | Y | N |

## Pulmonary System

| | | |
|---|---|---|
| Coughing | Y | N |
| Sputum production | Y | N |
| Coughing up blood | Y | N |
| Shortness of breath | Y | N |
| Wheezing | Y | N |
| Blue skin (cyanosis) | Y | N |
| Chest Pain | Y | N |

## Musculoskeletal System

| | | |
|---|---|---|
| Stiffness | Y | N |
| Popping noises | Y | N |
| Joint pain | Y | N |
| Weakness | Y | N |
| Limitation of movement | Y | N |
| Extremity deformities | Y | N |
| Difficulty walking | Y | N |

## Nervous System

| | | | | | |
|---|---|---|---|---|---|
| Partial paralysis | Y | N | Lack of coordination | Y | N |
| Complete paralysis | Y | N | Stroke | Y | N |
| Headache | Y | N | Speech abnormalities | Y | N |
| Loss of consciousness | Y | N | Visual disturbances | Y | N |
| Dizziness | Y | N | Walking disorders | Y | N |
| Memory loss | Y | N | Tremors | Y | N |
| Numbness | Y | N | Tics | Y | N |
| Weakness | Y | N | Sensory changes | Y | N |
| Mood Changes | Y | N | | | |

## Genital/Urinary System

| | | |
|---|---|---|
| Pain on urination | Y | N |
| Changes in urine flow | Y | N |
| Lump or mass in groin | Y | N |
| Kidney stones | Y | N |
| Chronic bladder infections | Y | N |
| Genital itching | Y | N |
| Changes in urination | Y | N |

## Special Senses

| | | |
|---|---|---|
| Visual problems | Y | N |
| Hearing loss | Y | N |
| Loss of balance | Y | N |
| Loss of taste | Y | N |
| Loss of smell | Y | N |
| Loss of touch sensation | Y | N |
| Temporary vision loss in one eye | Y | N |

## Reproductive System

| Male Only | | | Female Only | | |
|---|---|---|---|---|---|
| Testicular pain | Y | N | Abnormal vaginal bleeding | Y | N |
| Prostate problems | Y | N | Painful menstruation | Y | N |
| Infertility | Y | N | Breast lump/mass | Y | N |
| Impotence | Y | N | Vaginal discharge/itching | Y | N |
| Discharge | Y | N | Nipple discharge | Y | N |
| Lump or mass | Y | N | Infertility | Y | N |
| Male pattern baldness | Y | N | Abnormal periods | Y | N |

## Head and Neck Region

| | | | | | |
|---|---|---|---|---|---|
| Headaches | Y | N | Ringing in ears | Y | N |
| Neck Stiffness | Y | N | Ear pain | Y | N |
| Neck/lump mass | Y | N | Ear discharge | Y | N |
| Eye pain | Y | N | Ear itching | Y | N |
| Eye discharge | Y | N | Nasal discharge | Y | N |
| Double vision | Y | N | Sinus trouble | Y | N |
| Dry eyes | Y | N | Bad breath | Y | N |
| Excessive tearing | Y | N | Nasal obstruction | Y | N |
| Spinning sensation | Y | N | Snoring | Y | N |

# INFORMED CONSENT TO
# CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor or chiropractor named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral sprains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself, decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name and Address of Office or Clinic

Loveland Chiropractic Office
215 Loveland-Madeira Rd.
Loveland, OH 45140

Printed Name of treating Doctor

Jeffrey T. Kemmet, D.C.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative Date
(if minor or physically incapacitated)

_____ _____
Witness to Patient's signature Date

LOVELAND CHIROPRACTIC OFFICE, INC.

215 Loveland Madeira Rd. Loveland, OH 45140

(513) 683-1052

# OFFICE POLICY LETTER

**IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Medicaid and other health plans to: Loveland Chiropractic Offices, Inc., 215 Loveland Madeira Rd, Loveland, OH 45140.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of any medical records.

In the event that full payment for charges incurred connection with my medical care is not made, I agree to pay all costs of collection, including reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Hamilton, Ohio.

This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

**Signed _____** **Date _____**

**(RESPONSIBLE PARTY)**

## DESIGNATION OF AUTHORIZATION REPRESENTATIVE

I, _____, do hereby designate Jeffrey T. Kemmet, D.C. and Loveland Chiropractic Offices, Inc. (hereafter referred to "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I receive from my doctor.

**Signed _____** **Date_____**

**Loveland Chiropractic Offices**
215 Loveland-Madeira Rd.
Loveland, Oh 45140
(513) 683-1052

**Acknowledgement of Receipt of Notice of Privacy Practices**
**This form will be retained in your medical record.**

---

## NOTICE TO PATIENT

We are required to provide a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice**.**

I acknowledge that I received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Loveland Chiropractic Offices.

I understand that the Notices describes the uses and disclosures of my protected health information by Loveland Chiropractic Offices and informs me of my rights with respect to my protected health information. Please indicate other people (a spouse, significant other, or relative) you will allow this clinic to share aspects of your treatment and protected health information (including your medical information, billing information and/or scheduled appointments). You may choose to allow none.

**Authorization to Release Information**

| | | | |
|---|---|---|---|
| **1.** | **Name** | **Relationship** | **Phone** |
| **2.** | **Name** | **Relationship** | **Phone** |

Please indicate if you allow this clinic to leave information about your medical information, billing, and scheduled appointments (protected health information) in a voicemail or email as needed. Please initial each that you allow. You may choose to allow none.

**Are we allowed to: leave you a voicemail? Y/ N** _____(initial) **Send you an e-mail? Y / N** _____(initial)

Phone Number: _____ Email Address: _____

_____ _____
Patient's Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

_____ _____
Today's Date If Legal representative, Indicate Relationship

# Primary Care Physician (PCP)
# Name and Address Form

Patient Name: _____

PCP Name: _____

PCP Address: _____

_____

_____

PCP Phone: _____

PCP Fax: _____

----------OFFICE USE ONLY----------

Entered in computer on: _____ (date)

Initial: _____