

Patient Information – Prestonwood Chiropractic

Name: _____ Date: _____ DOB: _____ SS# _____ Sex: _____

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

Home Phone: _____ Work Phone: _____ Referred by: _____

CHIEF COMPLAINT / REASON FOR APPOINTMENT:

1. _____

Additional problems or concerns you would like addressed:

2. _____

3. _____

What treatment have you already received for these conditions:

How long have you had this complaint: _____

Is this condition due to: Auto Accident Work Injury Other Accident Illness Unknown Cause

Is the pain: Mild Moderate Severe Dull Sharp Burning Aching Stabbing

Circle the intensity of your pain: (0 = no pain, 10 = worst pain) 0 1 2 3 4 5 6 7 8 9 10

Are symptoms generally? Improving Getting worse About the same Intermittent (comes and goes) Constant

Does the pain radiate? Yes No If yes, describe _____

Have you had similar symptoms before? Yes No If yes, when? _____

Have you lost time from work? Yes No If yes, when? _____

Effect on Daily Activities? No effect Extra effort required Occasional limitation Frequent or severe limitation

PAST MEDICAL HISTORY (Circle any that are appropriate)

AIDS, HIV	Alcoholism	Allergies	Arthritis	Asthma	Cancer	High Cholesterol
Depression	Dizziness	Diabetes	Epilepsy	Hepatitis	Headaches	Herniated Disc
Stroke	Tumors	Tuberculosis	Thyroid	Scarlet Fever	Heart Disease	High Blood Pressure
Prostate	Pacemaker	Pinched nerve	Anemia	Chest Pain	Backaches	Sinus Trouble

Adverse reactions to medications / foods? _____

Any significant illnesses / injuries / accidents / surgeries?: _____

SOCIAL HISTORY:

Main Work Activity: Heavy Labor Light labor Mostly sitting Mostly standing Repetitive tasks

Family Physician: _____ Phone: _____

Patient Signature _____ Date _____

LIFESTYLE / SELF-CARE ISSUES

Have you ever smoked cigarettes? Yes No If yes, _____ packs per day, Smoked for _____ years.
Do you drink alcohol? Yes No Do you exercise regularly? Yes No
Have you had any broken bones? Yes No If yes, which ones? _____

Current Medications:

Current Vitamins / Nutritional Supplements:

REVIEW OF SYSTEMS: (check any significant problems you would like to discuss with the Dr.)

HEAD, NECK, SHOULDERS

- ___ Headaches
- ___ Head feels heavy
- ___ Lightheadedness
- ___ Fainting
- ___ Face flushed
- ___ Loss of memory
- ___ Eye Strain or Pain
- ___ Light bothers eyes
- ___ Blurred vision
- ___ Double vision
- ___ Loss of vision
- ___ Loss of balance
- ___ Dizziness
- ___ Loss of hearing
- ___ Pain in ears
- ___ Ringing in ears
- ___ Loss of taste
- ___ Loss of smell
- ___ Sinus trouble
- ___ Jaw clicks or pops
- ___ Grinding teeth
- ___ Neck Pain or Stiffness
- ___ Neck pain with movement:
 - ___ forward
 - ___ backward
 - ___ turning to the side
 - ___ bending to the side
- ___ Muscle spasms in neck
- ___ Grinding sounds in neck
- ___ Pain between shoulder blades
- ___ Pain in shoulder joint
- ___ Stiffness in shoulder
- ___ Difficulty raising arm
- ___ Pain in arms
- ___ Pain in hands
- ___ Pain in elbow
- ___ Numbness / Tingling in arms, hands, fingers
- ___ Loss of grip strength

MID-BACK, CHEST, ABDOMEN

- ___ Mid-back Pain or Stiffness
- ___ Pain around the ribs
- ___ Mid-back muscle spasms
- ___ Pain in kidney area
- ___ Chest pain
- ___ Shortness of breath
- ___ Wheezing or asthma
- ___ Coughing, dry or irritating
- ___ Coughing up mucous or blood
- ___ Irregular heartbeat
- ___ Abdominal Pain
- ___ Nausea
- ___ Nervous Stomach
- ___ Vomiting
- ___ Gas
- ___ Constipation
- ___ Diarrhea
- ___ Hemorrhoids

GENERAL

- ___ Anxiety
- ___ Nervousness
- ___ Depression
- ___ Fatigue
- ___ Difficulty sleeping
- ___ Recent weight gain
- ___ Recent weight loss
- ___ Fevers
- ___ Chills
- ___ Poor Appetite
- ___ Excessive Perspiration
- ___ Tremors
- ___ Allergies to Food or Environment
- ___ Seizures

LOW-BACK, LEGS, FEET

- ___ Low-back Pain or Stiffness
- ___ Low-back Pain when:
 - ___ working
 - ___ lifting
 - ___ stooping
 - ___ standing
 - ___ sitting
 - ___ bending
 - ___ coughing
 - ___ lying down
 - ___ walking
- ___ Muscle spasms in low back
- ___ Low back feels out of place
- ___ Pain in buttocks
- ___ Pain in hips
- ___ Pain down the leg
- ___ Leg cramps
- ___ Cramps in feet
- ___ Knee pain
- ___ Pins & Needles in legs or feet
- ___ Numbness in legs or feet
- ___ Swollen ankles or feet
- ___ Feet feel cold

WOMEN ONLY

- ___ Menstrual pain
- ___ Irregular period
- ___ Abnormal discharge
- ___ Tumors
- ___ Pelvic Pain

MEN ONLY

- ___ Urinary Frequency
- ___ Difficulty urinating
- ___ Pain during urination

Signature: _____

Date: _____

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. **All charges incurred at Prestonwood Chiropractic are your responsibility.** Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits. However, this office DOES NOT guarantee your insurance policy or payments.
2. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.
3. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.
4. If your insurance company requires their own claim forms, you are required to bring in the completed forms by your second visit and then as needed.
5. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.
6. Your insurance should pay within 45 days from the date in which it was filed.
7. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.
8. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.
9. Any overpayments made by your insurance company that credits your account will be refunded. However, any overpayments or errors in amounts paid that do not credit your account will be your responsibility.
10. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understood the policy regarding insurance assignments. I realize that I am ultimately responsible for all charges incurred by me at this office.

Signature

Date

Witness

Date

**Prestonwood Chiropractic
6217 Chapel Hill Blvd. Suite 100
Plano, TX 75093**

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority :

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any proceeds for medical treatment at Prestonwood Chiropractic that exist in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with **Article 21.55 of the Texas Insurance Code** or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 45 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with **Article 21.55 of the Texas Insurance Code**, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the results of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable amount of time. If, during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Signature of Patients and/or responsible parties:

1. _____

Date _____

2. _____

Date _____

Witness Signature: _____

Date _____