Chiropractic Health & Wellness Center
1398 Highway 35, Ocean NJ 07712 Phone: 732-531-0840 * Fax: 732-531-3330
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Patient Name:	Today's Date:
Address:	
City, State, Zip Code:	
Birth Date: _____ / _____ / _____ Age: _____	Gender (circle one): Male Female Unspecified Declines to specify
Home Phone:	Cell Phone:
Best number to reach you: ___ Home Phone ___ Cell Phone (___ Yes you may leave a message) ____ **Yes Text Msg**	
Primary Email: **(for appointment reminders)**	

Patient Condition and Office Policies

Additional Patient Information

Your Occupation _____ Employer _____

Emergency Contact Person: _____ Relationship to you _____

Emergency Contact Phone: _____

If referred to us, who can we thank? _____

Insurance Information

Person Responsible for insurance: _____ Date of birth _____/_____/_____

Insurance Company: _____ Policy Number: _____

Primary Care Physician _____ Phone # _____

Date of last physical examination? _____/_____/_____

Blood work done _____/_____/_____ Where? _____

Recent x-rays or other imaging _____/_____/_____ Where? _____

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Current condition

Complaint area #1: _____

Current pain: VAS: area of pain: _____ (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Describe your pain (check all that apply)	What is your pain frequency	What is the level of your pain
___ sharp	___ none (no pain)	___ none
___ dull	___ infrequent	___ minimal
___ stabbing	___ occasional	___ slight
___ achy	___ intermittent	___ moderate
___ radiating	___ frequent	___ severe
___ burning	___ constant	
___throbbing		

What aggravates it? _____

What relieves it? _____

Complaint area #2: _____

Current pain: VAS: area of pain: _____ (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Describe your pain (check all that apply)	What is your pain frequency	What is the level of your pain
___ sharp	___ none (no pain)	___ none
___ dull	___ infrequent	___ minimal
___ stabbing	___ occasional	___ slight
___ achy	___ intermittent	___ moderate
___ radiating	___ frequent	___ severe
___ burning	___ constant	
___throbbing		

What aggravates it? _____

What relieves it? _____

Approximately, when did your injury or condition occur? _____/_____/_____

What caused it? _____

Have you missed work or school due to your injuries? □ Yes □ No

Did you have any other treatment for this condition? _____

Have you ever had the same or similar condition? □ Yes □ No

If yes, when (please provide date) and describe: _____

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Social and Medical History

Do you smoke? □ Yes □ No # packs/day: _____ Do you drink alcohol? □ Yes □ No # drinks/day: _____

Do you exercise? □ Yes □ No What type: _____

Accidents/Injuries: _____

Surgeries / Medical Procedures: _____

Allergies: _____

Medications /drugs: _____

Supplements / Vitamins: _____

Are you having any weakness, tingling, or dizziness? _____

Have you been treated for any health condition by a physician in the last year? □ YES □ NO

Describe: _____

WOMEN ONLY: Are you pregnant? □ YES □ NO □ UNCERTAIN Number of Children: _____ Ages: _____

Please describe any symptoms or conditions relating to the following systems:

Heart: _____
Lungs: _____
Digestive System: _____
Urinary Tract: _____
Reproductive: _____

Past Medical History:

____Heart Disease	____ Diabetes		____ Cancer
____Stroke	____ High Blood Pressure		____ Thyroid Problems
____Prostate Disorder	____ Kidney Problems	____ Asthma	____ Ulcer

Family History:

_____

_____

_____

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Office Policies and Information

We strive to keep fees for all services affordable for all patients regardless of insurance plan.
Find your way back to health by making an investment in your long-term wellness.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I understand that Chiropractic Health and Wellness Center, and the doctors associated with this office, do not participate with all insurance plans. The office is out of network with several plans; fees for services rendered will be collected at the time of service for out of network plans and patients who do not present with insurance. Out of network insurance plans can be billed electronically at the patient's request. For in network plans, I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon the processing of my claims. If my insurance company does not pay on my charges at the estimated rate or within a reasonable amount of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

Insurance plans DO NOT cover all services; I understand that a complete list of services and fees is available. Nutritional consultations, supplements, durable medical equipment, and athletic taping / kinesiotape are just some examples of what is not covered regardless of whether in network or out of network. I understand that Chiropractic Health and Wellness Center is happy to discuss insurance coverage and fees at any time; and want all patients to receive the full care they require. Fees are transparent and reasonable.

I agree to assign any payment(s) made to this office (Chiropractic Health & Wellness Center) from my medical insurance provider for services rendered. This is a direct assignment of my rights and benefits under my medical insurance policy. I authorize this office to complete any forms and to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition.

Basic dietary or supplement recommendations may be made as part of my chiropractic treatment plan. The information is supplied to improve my overall nutritional status and support chiropractic wellness programs; but is NOT for the treatment of a specific disease, defect or deformity.

A fee of $30 may be charged for the requested completion of disability forms and other related paper work, to be filled out by the doctor and for the patient, but not related to insurance reimbursement. This service is not billable to insurance and the fee will be collected at the time of the request

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Regarding the Use & Disclosure of Protected Health Information (HIPAA)

For the purposes of this Consent Form, "Office" shall refer to: Chiropractic Health & Wellness Center, LLC.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form. I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent , but only to the extent that the Office has not taken action in reliance there on and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

By signing this consent, you are giving Chiropractic Health & Wellness Center permission to contact you regarding your treatment, billing and/or office events and information by phone, email, and/or mail at the contact information provided on this form.

I have read, understood, and agree to the foregoing. The information, which I have provided, is true and complete to the best of my knowledge.

Patient Name (please print): _____
(Guardian if under 18 years of age)

Patient Signature: _____ Date: ____/____/____

Consent to treat a minor

As parent/guardian of _____, I give my consent for evaluation and treatment.

Parent/Guardian Name_____ Date: ____/____/___

Parent/Guardian Signature_____

Parent/Guardian Telephone_____

Patient Request for Credit Card on File

For ease of payment for out of pocket expenses, I would like the office to keep a credit card on file in my secure electronic patient file. I give permission for this credit card to be used for out of pocket expenses and I will receive an email receipt (if requested). I understand that I can change or remove this card at any time, and that this is not required for care in the office.

CC#: _____ Exp: _____/_____ Verification Code: _____

Signature: _____ Date: _____