APPLICATION FOR TREATMENT

Date ________________________________

Name____Age_____________Birthdate___________

Address ____ City _______________ State _____ ZIP Code ____________

Home Phone Number ______________ Work _____________ Cell __________ How did you hear about us? __________________
Are You: Married___ Single___Widowed___Divorced___Separated___ Minor___ Social Security # ________________________

Employer ____ Occupation ______________________________________

WHAT is your e-mail address: ____
This will be used for our office newsletter and NOT solicitation.
Emergency Contact / Relationship? ____Phone Number________________________
Please describe the principal health problems for which you came to this office. _____________________________________
____
How and when did symptoms first occur? ____
List any other doctors seen for these problems ____
List type of treatment(s) ____
____
Does this interfere with your normal living and work? Yes____ No____ In what way? ________________________________
Have you lost any days of work? Yes____ No____ Dates ____
Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain _____________________________________
____
Who is responsible for your bill? Self ____ Spouse____ Parent____ Employer____ Insurance____ Other_____________

PAST HISTORY

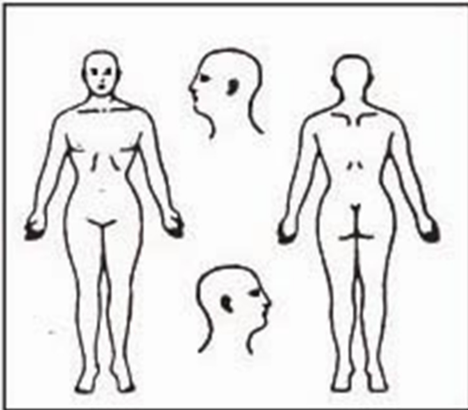
Has a physician treated you for any health condition in the last year? Yes___ No___; If yes, explain: __________________________
____
Who is family physician? _________________ May we send a report to them? _______________________
Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain _____________________
____
List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)
____
List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) ____________________
____

FAMILY HISTORY

Name of wife or husband ____ Ages of children ___________________________

Spouse's Employer ____ Business Phone _______________

<u>Please mark your areas of pain on the figures below</u>



List the conditions that you are most interested in getting corrected. **List <u>in order of importance:</u>**
1. ______________________________2. __________________________________
3. ______________________________4. __________________________________

What functions are you unable to perform or induce pain upon performance?
<u>List in order of severity</u>. (Example: sitting, walking, bending, lying down, etc.)
1. ______________________________2. __________________________________
2. ______________________________4. __________________________________

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient ____

PATIENT HEALTH QUESTIONNAIRE

Name____ Date ________________________________

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight Gain Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast Soreness Lumps
☐	☐	Cancer, Explain________________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Headache ______
☐	☐	Heart Attack (date)
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder problems
☐	☐	Loss of Appetite

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular In-coordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle or Foot
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Pain in Upper Leg or Hip
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain
☐	☐	Stroke (Date)_____________
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain___________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain
☐	☐	Other___________________

Have You or Your Family Had:

Yes	No	Condition
☐	☐	Cancer
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Chronic Back Problems
☐	☐	Heart Problems
☐	☐	Chronic Headaches
☐	☐	Lung Problems
☐	☐	High Blood Pressure
☐	☐	Lupus

Do you have a permanent disability rating? Yes__ No__
Location_______________________________________
Date rating received ? Rating Percentage__________

Present Weight _______Pounds Height _________Feet _______Inches

Please check any of the following that apply to you

Past	Present	Item
☐	☐	Pregnancy,# births____________
☐	☐	Birth control pills, Type________
☐	☐	Medication(list if not listed elsewhere) ________________________________ ________________________________

Past	Present	Item
☐	☐	Tobacco___ packs/day
☐	☐	Alcohol __drinks/day/week/month
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft drinks
☐	☐	______cups/cans per day

Past	Present	Item
☐	☐	Hospitalizations/Surgical Procedures (List if not described elsewhere)______________________

____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition.

____ ____________________

Signature **Date**

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly off the insurance form that we must fill out and file for you. Please answer as fully as possible.

* Type of insurance: Medicare____ Medicaid____ Group Health Plan ____ Other____

1. Patient name ______________________________
2. Insured's name (as it appears on the insurance card) ______________________________
   Insured's relationship to patient______________________________
   Insured's address (if same as patient, put same) ______________________________
   City______________________ State__________ ZIP_____________ Tel # ______________
   Insured's date of birth _______________ Sex: ____ Male ____ Female
   Insured's Social Security Number______________________________
   Employer name or school name ______________________________
3. Insured's ID number ______________________________
   Insured's Policy Group or FECA Number______________________________
   Insurance plan name or program name______________________________
4. Is there another health benefit plan? ______________________________
   Other insured's name (if applicable)______________________________
   Other insured's policy or group number______________________________
   Other insured's date of birth ____________________ Sex: ___ Male ___ Female
   Employers name or school name ______________________________
   Insurance plan name or program name ______________________________
5. Is the condition we are treating related to current or previous employment? Yes____ No____
6. Is the condition we are treating related to an auto accident? Yes____ No____ State_______________
7. Is the condition we are treating related to another type of accident? Yes ____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed____ Date________________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed____ Date________________

Medicare Only

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes_______ No_______
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes________ No_________
3. Is this illness or injury the result of an accident or other injury? Yes________ No__________
4. Is this illness or injury the result of an accident or illness that occurred at work? Yes_______ No__________
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes___ No____
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes_________ No__________
7. Do you have a Medicare Medigap Policy? Yes_________ No__________
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from) Yes___ No_____

Signature of person completing form ______________________________________ Date ___________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

For the Chiropractic Practice of:

BRIDGEPORT FAMILY CHIROPRACTIC
101 Steele Street
Bridgeport, WV 26330
304-842-7678

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal health care operations such as assessments and physician certifications.

Bridgeport Family Chiropractic and members of the practice staff may need to use my name, address, phone number and my clinical records to contact me with appointment reminders, information about treatment alternatives or other health related information that may be of interest to me. If this contact is made by phone and I am not at home, a message will be left on my answering machine or with a family member. By signing this form, I am giving BFC authorization to contact me with these reminders and information.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I my contact this organization at any tie at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide to such restriction.

____
Name of Patient (please print)

____
Signature of Patient Date

____
Signature of Patient Representative Date

____
Relationship of Patient Representative to Patient

____
Office Representative Date

____
Others to whom we may release your PHI