MIDWEST MEDICORP

Confidential Patient Information

Is your visit due to an accident? ☐Yes ☐ No Accident Date:

Type of Accident: Work☐ Auto / Traffic☐ Other☐ Was accident reported? ☐Yes ☐ No

Today's Date:____

☐Cell phone#____________________________________ ☐Email: ____

First Name: __________________________________ Middle Initial: ________ Last Name: _____________________________________

Address: ____

City: ____ State: ______________________ Zip Code: ______________________________

Home Phone#: (_______)______________-__________________ Work Phone#: (________)______________-__________________

Date of Birth: __________/__________/____________ Age: _____________ Sex: ☐Male ☐Female

Month Day Year

Social Security Number: _____________-_________-________________ Marital Status: ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other ___________________________

How did you hear about us/ Who referred you?____

Spouse / Parent_Data

First Name: ___________________________________ Middle Initial: ________ Last Name: ____________________________________

Relationship: __________________________________ Date of Birth: ___________/___________/____________

Month Day Year

Patient's Employer Data

Employer / Company Name: ____

Address: ____

City: ____ State: _________________________ Zip Code: ___________________________

Occupation:____ Employer Phone#: (________)______________-__________________

Emergency Contact

Contact Name:____ Contact Phone#: (_______) ________-____________

Insurance Data

Name of Insurance:____

ID#:________________________________ Policy#:______________________________ Group#:_____________________________

Policy Holder's Name:____ Date of Birth:__________/___________/___________

Month Day Year

For accident related: Claim # :_______________________________________ Phone#:(__________)_____________-________________

Adjustor Name:____

Have you been treated by any other physician for **this** condition? **☐Yes ☐ No**

Physician Name: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issue remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.

Patient's Signature: ____ Date: ______________________

Legal Guardian Signature: ____ Date: ______________________

Please present insurance card and picture ID to receptionist along with completed form.

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Patient Name: ____

Are your present problems due to an injury? ❑Yes ❑No

Enter the date of the injury:___________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other:

Has the accident been reported? ❑Yes ❑No

If so, to whom? ❑To Employer ❑Auto Carrier ❑Other

Briefly describe the accident, injury or illness:

____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity associated with the symptom

__________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

__________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies:____

❑Medications:____

Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: _____________ Date Released: _____________ Length of Stay: ____________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

__________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition

Off work: ❑Yes ❑No ❑Previously From: _________ To: ___________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____________

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Do you suffer from any condition other than that for which you are now consulting us?

❑Yes ❑No ____

List any past conditions you may have had:

____

HABITS

❑Smoking Packs/day: ______
❑Drinking/Alcohol: (Cups/day): ____
❑Coffee Cups/Day: ________
❑Soft Drink Cans/Day: ______
❑Water Cups/Day: ________

EXERCISE

❑None
❑Moderate
❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Brother(s)	❑	❑	❑	❑
Sister(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc?

❑Yes ❑No If yes, which ones?:____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?:

____

Do you have allergies? ❑Yes ❑No If yes, which ones?: ____________________________

Have you ever had X-rays taken? ❑Yes ❑No When? ______________________________

For what ailments were these X-rays taken? _____________________________________

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS **GASTRO-INTESTINAL** **EYE/EAR/NOSE/THROAT** **RESPIRATORY**

❑ Allergy(What) ___________ ❑ Belching or Gas ❑ Asthma ❑ Chest Pain
❑ Bronchitis ❑ Colon Trouble ❑ Deafness ❑ Chronic Cough
❑ Headache ❑ Constipation ❑ Earache ❑ Spitting Blood
❑ Convulsions ❑ Diarrhea ❑ Ear Discharge ❑ Spitting Phlegm ❑
Dizziness ❑ Gall Bladder ❑ Ear Noises ❑ Fainting
❑ Hemorrhoids (piles) ❑ Thyroid Problems ❑ Loss of Sleep ❑ Nausea
❑ Nasal Obstruction ❑ Blood in Urine ❑ Loss of Weight ❑ Stomach Pain ❑ Nose
Bleeds ❑ Frequent Urination ❑ Nervousness ❑ Vomiting ❑ Pain in
Eyes ❑ Urination Control ❑ Night Sweats ❑ Vomiting Blood ❑ Poor Vision
❑ Kidney Infection ❑ Numbness in ___________________
❑ Heart Burn ❑ Blurred Vision ❑ Kidney Stones ❑ Wheezing
❑ Bloody Stools ❑ Sinusitis ❑ Painful Urination

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis ❑Anemia ❑Heart Disease ❑Arthritis ❑Pneumonia

❑Measles ❑Goiter ❑Epilepsy ❑Rheumatic Fever ❑Mumps

❑Influenza ❑Mental Disorder ❑Polio ❑Chicken Pox ❑Pleurisy

❑Lumbago ❑Tuberculosis ❑Diabetes ❑Alcoholism ❑Eczema

❑Whooping Cough ❑Cancer ❑Venereal Disease ❑HIV Positive

Please present insurance card and picture ID to receptionist along with completed form.

Describe accident including surrounding circumstances____
____

Party responsible for payment: ____ Claim #: ____________________

Have you been contacted by an insurance company adjustor or company representative about claim? ☐Yes ☐ No

Have you retained an attorney? ☐Yes ☐ No Attorney Name: ____

Attorney Address & Phone#:____

Patient Signature:____ Date:____________________

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Patient's Signature:____ Date: _________

Legal Guardian Signature: ____ Date: _________

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PATIENT AGREEMENTS & AUTHORIZATION

CONSENT FOR TREATMENT __________

I hereby consent to the treatment provided by Midwest Chiropractic and Element Wellness ("Practice") and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION__________

I authorize use and disclosure of my personal health information for the purposes of diagnosing and/or providing treatment to me, obtaining payment for my care and/or for the purposes of conducting the health care operations of the practice. I authorize the practice to release any personal health information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE __________

I authorize payment to be made directly to the practice for insurance benefits payable to me. I understand that I am financially responsible to the practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to collections I am responsible, including any reasonable attorneys fees.

X-RAY RELEASE__________

Our office sends out our x-rays to Gregerson Radiology Consultants for readings and the following disclaimer needs to be signed by all patients:

I understand that a fee will be charged for the interpretation of my x-rays, independent of any financial agreement made with my referring physician, and that I am personally responsible for this fee. I understand that, if applicable, my insurance company may be billed directly by Gregerson Radiology Consultants and that I am personally responsible for any portion of my bill not met by my particular policy, no matter what the reason. I recognize that all outstanding charges are due within 30 days of receipt of my billing statement. I understand that if a balance is not paid within three billing statement that I may have my account sent to collections. I assign and authorize direct payment of any insurance benefits to be paid to Gregerson Radiology Consultants for their professional radiology services. I also authorize release of any medical information concerning my case.

PRIVACY___________

I acknowledge having received the practice's, "Notice of Privacy Policies". My rights, which include the right to see and copy my record, to limit disclosure of my private health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent.

CONSENT FOR TREATMENT OF A MINOR CHILD__________

I hereby authorize Midwest Chiropractic to administer treatment as they so deem necessary to my son/daughter____of minor age.

______________________________	______________________________
Print Name	Patient Signature or Authorized Person (Legal Guardian)
______________________________	______________________________
Relationship	Date
______________________________	______________________________
Witness Signature Patient unable to sign. Verbal consent given	Date

Reason: ___________________________________

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