ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.
PLEASE FILL OUT THE PERSONAL INFORMATION BELOW.
IF YOU NEED ASSISTANCE, PLEASE INFORM THE RECEPTIONIST. THANK YOU!

First Name______________________ Middle________________ Last______________________

Gender __Male __Female Home Phone________________ Cell Phone________________

Address____

City____________________________ State_________________ Zip____________________

Social Security Number__________________ E-mail Address____________________________

Birth Date________________Age________ **Marital Status** S M W D

Job Title______________________________ Work Phone______________________________

Spouse's Name________________________ Spouse's Birth Date__________________________

Social Security Number__________________

Person responsible for this account____

Name of person on your health insurance card____

Name of their employer_____________________ City_________________________________

Employer's Phone____

Children – Names & Ages____

In case of emergency, who should we contact?____

Phone______________________________

Family Physician____

What is your primary complaint____

____

IS THIS WORKMAN'S COMPENSATION?______ IS THIS PERSONAL INJURY?______

Patient Informed Consent

I,_____________________, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exams(s) and hereby consent to any similar subsequent treatment(s) or exams. If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature______________________________

(Office use only) **Account Number** **Date**

Name____________________ **Date**________________ **Account#**________________

History of Illness / Injury / Pain

Chief complaint and it's location: ____

What caused the onset?: ____

Date of onset?: ____/____/_____

How often do you experience this pain? ____ Constant ____Frequent ____Intermittent ____Occasional

Use the key below to rate the severity of your pain.
0 = None 1 = Minimum 2 = Very mild 3 = Mild 4 = Mild to moderate 5 = Moderate 6 = Moderate to severe
7 = Mildly severe, restricts some activity 8 = Severe, limits most activity 9 = Very severe 10 = Excruciating

Sitting here today, what is the intensity of your pain? 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been? 0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been? 0 1 2 3 4 5 6 7 8 9 10

How does the symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps
Other:____

How would you best describe the sensation of the pain/symptom:

____Deadness	____Prickly	____Numb	____Crawling	____Tingling
____Stabbing	____Hurting	____Pulsating	____Pins & Needles	____Pounding
____Burning	____Shooting	____Throbbing	____Stinging	
____Dull	____Sharp	____Aching	____Excruciating	

If this pain/symptom radiates or travels, please identify where to:____________________________

What aggravates the pain/symptom?

____Flashing lights	____Sneezing	____Lifting	____Exercising	____Looking up/down
____Coughing	____Sitting	____Stooping	____Looking side/side	____Anger
____Standing	____Depression	____Stress	____Driving	____Walking
____Getting out of bed	____Pushing	____Emotional upset	____Pulling	____Repetitive motion
____Carrying	____Straining at BM	____Climbing stairs	____Walking up hill	____Getting in/out of car

Other:____

What relieves the pain/symptom?

____Resting	____Sleeping	____Cold	____Heat	____Sitting	____Exercise/Movement
____Shower	____Advil	____Aspirin	____Tylenol	____Pain pills	____Treatment
____Mineral ice	____Other:____________				

Over the past month this complaint is: ____Improving ____Getting worse ____About the same

Patient history was obtained from: ____Patient ____Father ____Mother ____Son ____Daughter

Have you seen anyone for this condition? ____Yes ____No Whom?________________________

Do you have a pacemaker? ____Yes ____No

Are you pregnant? ____Yes ____No
Do you think you may be pregnant? ____Yes ____No

Patient signature________________________ Doctor signature________________________

Patient signature________________________ Doctor signature________________________

Name________________________ **Date**________________ **Account#**________________

Y	N	Past Problem	When and Explanation of Condition
		Cancer	
		Balance problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		MRSA	
		Other	

Surgery	Yes	No	Year	Surgery	Yes	No	Year
Tonsils				**WOMEN**			
Colon				Breast			
Hernia				Uterus			
Appendix				Ovaries			
Gall Bladder				**MEN**			
Stomach				Prostate			
Heart				Other			
Kidney							
Other							

What other major injuries have you had? Date	Have you ever taken:			
	Insulin			
	Cortisone			
	Thyroid Medicine			
	Male/Female hormones			
What medications are you currently taking? Date	Blood Pressure			
	Tranquilizers/Sedatives			
	Birth Control			
Hospitalizations:				

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complain

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

____

PATIENT

____

DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other
Details:

____

Signature of Practice

____

Date

Patient signature_______________________________Doctor signature_______________________________

Westport Chiropractic

Financial Agreement

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

IN ORGER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE AT TIME OF SERVICE.

The undersigned hereby agrees to pay the provider for services rendered during this visit. If your account is forwarded to a collection agency or attorney, you will be responsible for any collection fees, court costs, reasonable attorney fees, and interest allowed by state statute, incurred in the collection of your account. By signing this, you agree to be called by an Auto/Predictive Dialer at any phone you may have, home and or cell, in connection with this debt, now and in the future.

I authorize the release of any information necessary top determine liability for payment and to obtain reimbursement on any claim.

_______________________________   _______________________________
PATIENT SIGNATURE   INSURED'S SIGNATURE

____
DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health benefits coverage with the above captioned, and hereby assign and convey directly to Westport Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim medical benefits reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extant permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_______________________________   _______________________________
Signature of Insured/Guardian   Date

NAME:______________________________ DATE ____/____/______ Account#:____________________

REVIEW OF SYSTEMS

Y	N		PN	Y	N		PN	Y	N		PN	Y	N		PN
		Weakness				Muscle pain				Seizures				Animal dander	
		Fatigue				Muscle weakness				Vertigo				Latex	
		Fever				Muscle cramps				Dizziness				Food allergies	
		Chills				Joint stiffness				Tremors				Penicillin	
		Night sweats				Joint tenderness				Loss of sensation				Pollen	
		Fainting				Spinal curvature				Loss of coordination				Second hand smoke	
		Nervousness				Back pain				Weak grip				Grasses	
		Concent. loss				Hot joints				Paralysis				Sulfa drugs	
		Dizzy spells				Joint swelling				Difficulty of speech				Dairy products	
		Irritability				Stiff neck				Tingling				Perfumes	
		Depression				Soreness				Numbness				Hay	
		Memory loss				Lumps									
		Loss of sleep				Masses									
		Headache													
		Apprehension													

Check additional form for additional Review of Systems

OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE

_____Previous Review of Systems reviewed. Date of previous Review of Systems was: _____/_____/________

System Reviewed

_____Constitutional _____Musculoskeletal _____Neurological _____Allergic

_____Other, please note: ____

_____No change in systems review

_____Previous Past History reviewed and updated. Date of Past History update: _____/_____/________

_____No change in Past History _____See old Past History for changes

_____Previous Social History reviewed and updated. Date of Social History updated: _____/_____/________

_____No change in Social History _____See old Social History for changes

_____Previous Family History reviewed and updated. Date of Family History updated: _____/_____/________

_____No change in Family History _____See old Family History for changes

Patient Signature______________________________ Doctor Signature______________________________

NAME:______________________________________ DATE ____/____/______ Account#:____________________

SECONDARY COMPLAINT & LOCATION

Location______________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the least intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the most intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps

Other: ______________________________________

How would you best describe the sensation of the pain/symptom:

____Deadness	____Prickly	____Numb	____Crawling	____Tingling
____Stabbing	____Hurting	____Pulsating	____Pins & Needles	____Pounding
____Burning	____Shooting	____Throbbing	____Stinging	
____Dull	____Sharp	____Aching	____Excruciating	

Over the past weeks/months this complaint is: _____Improving _____Getting Worse _____About the Same

THIRD COMPLAINT & LOCATION

Location______________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the least intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the most intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps

Other: ______________________________________

How would you best describe the sensation of the pain/symptom:

____Deadness	____Prickly	____Numb	____Crawling	____Tingling
____Stabbing	____Hurting	____Pulsating	____Pins & Needles	____Pounding
____Burning	____Shooting	____Throbbing	____Stinging	
____Dull	____Sharp	____Aching	____Excruciating	

Over the past weeks/months this complaint is: _____Improving _____Getting Worse _____About the Same

FOURTH COMPLAINT & LOCATION

Location______________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the least intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the most intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps

Other: ______________________________________

How would you best describe the sensation of the pain/symptom:

____Deadness	____Prickly	____Numb	____Crawling	____Tingling
____Stabbing	____Hurting	____Pulsating	____Pins & Needles	____Pounding
____Burning	____Shooting	____Throbbing	____Stinging	
____Dull	____Sharp	____Aching	____Excruciating	

Over the past weeks/months this complaint is: _____Improving _____Getting Worse _____About the Same

Patient Signature______________________________ Doctor Signature______________________________

NAME:________________________ DATE ____/____/______ Account#:________________

Marital Status: _____Married _____Divorced _____Single _____Separated _____Widowed

Number of Children: ________

Frequency of exercise: _____Never _____Rarely _____Occasionally _____Moderately _____Regularly

Intensity of exercise: _____Low Level _____Medium Level _____High Level _____Competition Level

Sufficient rest: _____Never _____Rarely _____Occasionally _____Moderately

Hours of sleep: _____ _____10 or more hours

Well balance diet: _____Never _____Rarely _____Occasionally _____Moderately

Do you Smoke?
_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 packs/day

Do you drink caffeinated beverages?
_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 drinks/day

Do you drink alcoholic beverages?
_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 drinks/day

Have you ever used street drugs? _____Yes _____NO

Hobbies: ____
____
____

How did you hear about us? ____

Over 70% of our patients bring in their spouse and children to get adjusted. If you would like to have your spouse or child checked please mark the box below and they will receive a complimentary consultation,, exam and xray's as needed if scheduled within 2 weeks of you starting care. This exam is at no cost to you and does not obligate them to receive future care. (You have the right to rescind within seventy two hours the obligation to pay for services rendered in addition to this free offer)

☐ I would like my family members to be checked in the next two weeks.

Patient Signature________________________ Doctor Signature________________________