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 let us know. Thank you!

FIRST NAME ______________________ MIDDLE ______________ LAST __________________________

GENDER ___ MALE ___ FEMALE HOME PHONE _________________ CELL PHONE __________

ADDRESS ____

CITY ____________________ STATE _______ ZIP ______________

SOCIAL SECURITY NUMBER ___________________ EMAIL ADDRESS ______________________________

BIRTH DATE ______________ AGE _______ MARITAL STATUS (CIRCLE ONE) S M W D

JOB TITLE ____________________________________ WORK PHONE _______________________

SPOUSE'S NAME _______________________________ SPOUSE'S BIRTH DATE _________________

SPOUSE'S SOCIAL SECURITY NUMBER _____________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT ____

NAME OF PERSON ON YOUR HEALTH INSURANCE CARD ______________________________________

NAME OF THEIR EMPLOYER __________________________________ CITY ___________________________

EMPLOYER'S PHONE NUMBER _____________________________

CHILDREN - NAMES & AGE ____

INCASE OF EMERGENCY, WHO SHOULD WE CONTACT? ____

PHONE _________________________________

FAMILY PHYSICIAN _______________________________ **PHONE** ______________________________

WHAT IS YOUR PRIMARY COMPLAINT ____

____

IS THIS WORKMAN'S COMPENSATION? _______ **IS THIS PERSONAL INJURY?** __________

Patient Informed Consent

I, ____, theundersigned 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 protions of my body that may be examined. I understand and consent to the clinic staff providing me wiht verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exams. If I do not consent, I will immediately infor 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 LOCATION ________________________________

WHAT CAUSED THE ONSET? ________________________________

DATE OF ONSET ______________

HOW OFTEN DO YOU EXEPERIENCE THIS PAIN? ___ CONSTANT ___ FREQUENT ___ INTERMITTENT ___ OCCASIONAL

USE THE SCALE BELOW TO RATE THE SEVERITY OF YOUR PAIN (CIRCLE THE CORRESPONDING NUMBER)

0 = NONE 1 = MINIMAL 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? 1 2 3 4 5 6 7 8 9 10

WHAT IS THE LEAST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10

WHAT IS THE MOST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10

HOW DOES THE SYMPTOM AFFECT YOUR MOVEMENT?
___ INFLEXABILITY ___ 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 AGGREVATES THE PAIN/SYMPTOM

___ FLASHING LIGHTS	___ SNEEZING	___ LIFTING	___ EXERCISING	___ LOOKING UP/DOWN
___ COUGHING	___ SITTING	___ STOOPING	___ LOOKING SIDE/SIDE	___ EMOTIONAL UPSET
___ STANDING	___ DEPRESSION	___ STRESS	___ DRIVING	___ GETTING OUT OF BED
___ WALKING	___ PUSHING	___ ANGER	___ 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	___ SITTING	___ EXERCISE/MOVEMENT
___ SHOWER	___ ADVIL	___ ASPRIN	___ 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 COULD BE PREGNANT ___ YES ___ NO

PATIENT SIGNATURE ______________ DOCTOR SIGNATURE ______________

NAME ______________________ DATE ______________ ACCOUNT # __________

HISTORY OF ILLNESS/INJURY/PAIN

SECONDARY COMPLAINT & LOCATION

LOCATION ____

SITTING HERE TODAY, WHAT IS THE INTENSITY OF YOUR PAIN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE LEAST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE MOST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10

HOW DOES THE SYMPTOM AFFECT YOUR MOVEMENT?

___ INFLEXABILITY ___ 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 MONTH THIS COMPLAINT IS: ___ IMPROVING ___ GETTING WORSE ___ ABOUT THE SAME

THIRD COMPLAINT & LOCATION

LOCATION ____

SITTING HERE TODAY, WHAT IS THE INTENSITY OF YOUR PAIN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE LEAST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE MOST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10

HOW DOES THE SYMPTOM AFFECT YOUR MOVEMENT?

___ INFLEXABILITY ___ 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 MONTH THIS COMPLAINT IS: ___ IMPROVING ___ GETTING WORSE ___ ABOUT THE SAME

FOURTH COMPLAINT & LOCATION

LOCATION ____

SITTING HERE TODAY, WHAT IS THE INTENSITY OF YOUR PAIN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE LEAST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10
WHAT IS THE MOST INTENSE THE SYMPTOM HAS BEEN? 1 2 3 4 5 6 7 8 9 10
HOW DOES THE SYMPTOM AFFECT YOUR MOVEMENT?

___ INFLEXABILITY ___ STIFFNESS ___ SPASMS ___ CRAMPS OTHER ______________

OVER THE PAST MONTH THIS COMPLAINT IS: ___ IMPROVING ___ GETTING WORSE ___ ABOUT THE SAME

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	

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	Y	N	YEAR	SURGERY	Y	N	YEAR
TONSILS				**WOMEN**			
COLON				*BREAST*			
HERNIA				*UTERUS*			
APPENDIX				*OVARIES*			
GALL BLADDER							
STOMACH				**MEN**			
HEART				*PROSTATE*			
KIDNEY				*OTHER*			
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							

PATIENT SIGNATURE ______________________ DOCTOR SIGNATURE ______________________

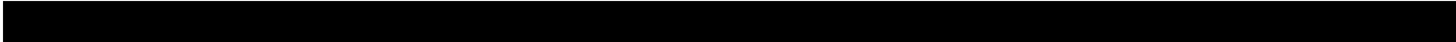
NAME ______________________ DATE ____________ ACCOUNT # ________

REVIEW OF SYSTEMS

Y	N		NP	Y	N		NP	Y	N		NP	Y	N	ALLERGIES	NP
		WEAKNESS				MUSCLE PAIN				SIEZURES				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				LOS OF COORDINATION				SECOND HAND SMOKE	
		NERVOUSNESS				BACK PAIN				WEAK GRIP				GRASSES	
		CONCENTRATION 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 ____________

SYSTEMS REVIEWED

______ CONSTITUTIONAL ______ MUSCULOSKELETAL ______ NEUROLOGICAL ______ ALLERGIC

______ OTHER ______________________

______ 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 UPDATE ____________

______ NO CHANGE IN SOCIAL HISTORY ______ SEE OLD SOCIAL HISTORY FOR CHANGES

______ PREVIOUS FAMILY HISTORY REVIEWED AND UPDATED DATE OF FAMILY HISTORY UPDATE ____________

______ NO CHANGE IN FAMILY HISTORY ______ SEE OLD FAMILY HISTORY FOR CHANGES

PATIENT SIGNATURE ______________________ DOCTOR SIGNATURE ______________________

NAME ______________________________ DATE ________________ ACCOUNT # ______________

MARITAL STATUS ___ MARRIED ___ DIVORCED ___ SINGLE ___ WIDOWED

NUMBER OF CHILDREN ______

FREQUENCY OF EXERCISE ___ NEVER ___ RARELY ___ OCCASIONALLY ___ MODERATELY ___ REGULARLY

INTENSITY OF EXERCISE ___ LOW ___ MEDIUM ___ HIGH ___ COMPETITION LEVEL

SUFFICIENT REST ___ NEVER ___ RARELY ___ OCCASIONALLY ___ MODERATELY

NUMBER OF HOURS OF SLEEP PER NIGHT ______

DO YOU SMOKE ___ YES ___ NO IF SO, HOW MUCH ________ HOW OFTEN ____________

DO YOU DRINK CAFFINATED DRINKS ___ YES ___ NO IF SO, HOW MUCH ________ HOW OFTEN ________

WHAT ARE YOUR HOBBIES ____

____

____

HOW DID YOU HEAR ABOUT US ______________________________________

PATIENT SIGNATURE ________________________ DATE ________________

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

The undersigned hereby agrees to pay the provider for services rendered during the 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 number you may have, home or cell, in connection with this debt, now and in the future.

I authorize the release of any information necessary to 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 names doctor and clinic and the extent permissible under the law to claim such medical benefits, insurance reimbursement and any application remedies. Further, in response to any reasonable request for cooperation, I agree to cooperation 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 in my name but at such doctor and clinic's expenses.

This assignment with 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

Patient Signature: ______________________________ Doctor Signature: ________________________________

PRACTICE REQUIREMENTS

The Practice:

A. Is required by federal law to maintain the privacy of your Protected Health Information (PHI) and to provide you with the 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 complaint.

Effective Date

This notice is in effect as of July 26, 2004.

Patient Acknowledgement

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

Patient Signature: ______________________________________ Date: _______________________________

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of this notice could not be obtained because:

- ☐ Patient refused to sign
- ☐ Communication barrier prohibited obtaining acknowledgement
- ☐ Emergency Circumstances
- ☐ Other

Explain:____

Practice Signature: _____________________________ Date: _______________________________