

PAST HEALTH FORM

THE FOLLOWING MAY SEEN UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT, HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CHIROPRACTIC CARE.

PLEASE CHECK ALL THAT APPLY MAJOR SURGERIES/OPERATIONS:

- APPENDECTOMY TONSILLECTOMY GALL BLADDER HERNIA BACK SURGERY
 BROKEN BONES OTHER: _____

MAJOR ACCIDENT OR FALLS (OTHER THAN WHAT YOU ARE BEING SEEN FOR TODAY) _____

HOSPITALIZATION (OTHER THAN ABOVE) _____

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING _____

DO YOU WEAR A SHOE LIFT? YES NO

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | | |
|--|--------------------------------------|--|---|--|
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> PLEURISY | INTAKE
<input type="checkbox"/> COFFEE, CUPS/DAY _____
<input type="checkbox"/> TEA CUPS/DAY _____
<input type="checkbox"/> ALCOHOL, DRKS/WK _____
<input type="checkbox"/> CIGARETTES, PK/DAY _____
<input type="checkbox"/> WHITE SUGAR |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> MEASLES | <input type="checkbox"/> CANCER | <input type="checkbox"/> ARTHRITIS | |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> MUMPS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> EPILEPSY | |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SMALL POX | <input type="checkbox"/> THYROID | <input type="checkbox"/> MENTAL DISORDERS | |
| <input type="checkbox"/> WHOOPING COUGH | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> INFLUENZA | <input type="checkbox"/> LUMBAGO | |
| | | | <input type="checkbox"/> ECZEMA | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD REGULARLY THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- LOW BACK PAIN
- PAIN BETWEEN SHOULDERS
- NECK PAIN
- ARM PAIN
- JOINT PAIN/STIFFNESS
- WALKING PROBLEMS
- DIFFICULT CHEWING/CLICKING JAW
- GENERAL STIFFNESS

NERVOUS SYSTEM

- NERVOUSNESS
- NUMBNESS
- PARALYSIS
- DIZZINESS
- FORGETFULNESS
- CONFUSION/DEPRESSION
- FAINTING
- CONVULSIONS
- COLD/TINGLING EXTREMITIES
- STRESS

GENERAL

- FATIGUE
- ALLERGIES
- LOSS OF SLEEP
- FEVER
- HEADACHES

GASTRO-INTESTINAL

- POOR/EXCESSIVE APPETITE
- EXCESSIVE THIRST
- FREQUENT NAUSEA
- VOMITING
- DIARRHEA
- CONSTIPATION
- HEMORRHOIDS
- LIVER PROBLEMS
- GALL BLADDER PROBLEMS
- WEIGHT TROUBLE
- ABDOMINAL CRAMPS
- GAS/BLOATING AFTER MEALS
- HEARTBURN
- BLACK/BLOODY STOOL
- COLITIS

GENTO-URINARY

- BLADDER TROUBLE
- PAINFUL/EXCESSIVE URINATION
- DISCOLORED URINE

EENT

- VISION PROBLEMS
- DENTAL PROBLEMS
- SORE THROAT
- EAR ACHEs
- HEARING DIFFICULTY
- STUFFED NOSE

C-V-R

- CHEST PAIN
- SHORT BREATH
- BLOOD PRESSURE PROBLEMS
- IRREGULAR HEARTBEAT
- HEART PROBLEMS
- LUNG PROBLEMS/CONGESTION
- VARICOSE VEINS
- ANKLE SWELLING
- STROKE

MALE/FEMALE

- MENSTRUAL IRREGULARITY
- MENSTRUAL CRAMPS
- VAGINAL PAIN/INFECTION
- BREAST PAIN/LUMPS
- PROSTATE/SEXUAL DYSFUNCTION
- OTHER PROBLEMS:

FEMALES ONLY:

WHEN WAS YOUR LAST PERIOD? _____
ARE YOU PREGNANT YES NO NOT SURE

FAMILY HISTORY

THE FOLLOWING MEMBERS HAVE A
SAME OR SIMILAR PROBLEM AS I DO:

<input type="checkbox"/> MOTHER	<input type="checkbox"/> SISTER
<input type="checkbox"/> FATHER	<input type="checkbox"/> SPOUSE
<input type="checkbox"/> BROTHER	<input type="checkbox"/> CHILD

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check, and CareCredit.
- Your insurance policy is a contract between you and your insurance company. **It is not our responsibility to keep track of your benefits or whether you are about to exhaust your benefits. Patients are expected to monitor this as they would their bank account.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We cannot be held accountable for any false or misinformation given to our office by you or your insurance carrier.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fee, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks plus our banks NSF Charge at the time. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Date: _____

Witness Signature: _____

Printed Name of Witness: _____

Date: _____

_____ Patient initials to indicate copy received.

**CHIPPEWA CHIROPRACTIC CLINIC
LOUIS D'AMICO, DC
STEPHANIE L SWITZER, DC**

WORK-RELATED ACCIDENT REPORT

NAME _____ **DATE** ____/____/____

ACCIDENT DATE ____/____/____ **TIME** _____

LOCATION ACCIDENT OCCURRED _____

DESCRIBE ACCIDENT IN DETAIL _____

DESCRIBE YOUR SYMPTOMS IN DETAIL _____

ANY PRIOR WORK COMP INJURIES/HISTORY _____

DID YOU REPORT THIS TO YOUR EMPLOYER YES NO

IS THIS INJURY WORK RELATED YES NO

DOES YOUR EMPLOYER HAVE A LIST OF AT LEAST 6 GEOGRAPHICALLY ACCESSIBLE HEALTH CARE PROVIDERS PROMINENTLY POSTED AT WORK YES NO

IS THERE A CHIROPRACTOR ON THIS LIST YES NO UNKNOWN

WERE YOU GIVEN A PERSONAL NOTICE OF THE LIST BEFORE YOU EVER HAD A WORK-RELATED INJURY
 YES NO

EMPLOYER'S ADDRESS _____

EMPLOYER CONTACT PERSON _____

PHONE () _____

PHONE () _____

PATIENT SIGNATURE _____

DATE _____

WORKMAN'S COMPENSATION EXPLANATION

TO OUR PATIENTS:

Because you have just suffered a work-related injury, we would like for you to understand how your case will be handled in our office. The first thing that you need to know is that the insurance carrier for your employer is financially responsible **ONLY** for treatment of your physical condition which is a result of employment-related incident. Your workers' compensation insurance will pay for treatment which restores your health to a pre-injury status.

You may be experiencing symptoms or problems that you suffered prior to your injury, and these may be contributing to your injury, so a judgment will be made as to what extent these factors have on your present injury. We will advise your workers' compensation insurance carrier as to the apportionment of these factors. It is very important for you to follow my orders and keep your scheduled appointments. The Workers' Compensation Law requires that if you do not receive the care that is necessary for your case your workers' compensation benefits must be discontinued and your case closed. It is also very important to notify your employer and this office of any re-injury or aggravations during your course of treatment.

We thank you warmly for the opportunity to serve you and welcome any questions that you may have concerning your case.

Sincerely,

Dr. Louis D'Amico, DC

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

PATIENT'S SIGNATURE

DATE