HELPING HANDS CHIROPRACTIC *WELCOME*

ABOUT YOU!

Today's Date:

PATIENT: _____
Name Last First MI

Name you prefer:_____ M_ F_

Birthdate:_____--_____-_____

SSN: _____--_____--_____

Mailing address:_____

_____
City State Zip

Home phone: _____--_____--_____

Cell phone: _____--_____-- _____

Work phone: _____--_____--_____

E-mail: _____

Referred by: _____

Employer: _____

Employer's address: _____

_____
City State Zip

Occupation: _____

Significant other / Spouse: _____

Do you have children? Yes No How many? ____

Are you: a minor married single divorced separated widowed ?

Person ultimately responsible for account

Name: _____

Relation: _____

Billing address:_____

_____
City State Zip

SSN#: _____--_____--_____

Driver's license #: _____

Work phone #: _____

Payment method: Cash _____ Check _____

Credit card (enter card # below if accepted here)

_____

_____ I hereby authorize assignment of my insurance
(Initials) rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered by this office).

INSURANCE INFORMATION
OFFICE USE ONLY, PLEASE

Insurance company:

Claims address: _____

_____
City State Zip

Claims Phone #: _____

Insured's name:_____

Birthdate: _____--_____--_____

Relationship to patient: _____

Employer: _____

Address: _____

_____
City State Zip

Effective date: _____

Policy #: _____

Group #: _____

Chiropractic benefits: Y__ N __

Referral from provider needed: Y__ N __

Pre-certification needed: Y__ N __

UHC/Great West: **ACN** notification? Y__ N __

NETWORK	IN	OUT
Deductible	_____	_____
Deduct. met?	_____	_____
Co-pay?	_____	_____
Co-insurance?	_____	_____
Insurance pays %	_____	_____
Patient pays %	_____	_____
Max # visits / year	_____	_____
Max benefits / year	_____	_____
Max modalities / visit:	_____	_____

Patient co-pay for evaluation? $

contact: Card copied? Y N

In the event of an EMERGENCY

We should contact: _____

Relationship to patient: _____

Home / Cell phone: _____/_____

Work phone: ____-_____--_____Ext _____

Who is your medical doctor? _____

MD's phone #:

Please continue on back – Thank you! >>>>>>

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

PATIENT HEALTH INFORMATION

1. MAJOR COMPLAINT('S) _____

_____

_____

2. CHECK YOUR PRESENT AND PAST SYMPTOMS

PRESENT	PAST		PRESENT	PAST	
☐	☐	NECK PAIN	☐	☐	EXCESSIVE THIRST
☐	☐	MIDDLE BACK PAIN	☐	☐	CHRONIC COUGH
☐	☐	LOW BACK PAIN	☐	☐	CHRONIC SINUSITIS
☐	☐	HEADACHE	☐	☐	GENERAL FATIGUE
☐	☐	DIZZINESS	☐	☐	PAINFUL URINATION
☐	☐	CONVULSIONS	☐	☐	FREQUENT URINATION
☐	☐	FAINTING, VISUAL DISTURBANCES, NAUSEA	☐	☐	ABDOMINAL PAIN
☐	☐	SHOULDER PAIN	☐	☐	DIFFICULTY IN SWALLOWING
☐	☐	PAIN IN UPPER ARMS OR ELBOWS	☐	☐	DEPRESSION
☐	☐	HAND PAIN	☐	☐	HIGH BLOOD PRESSURE
☐	☐	PAIN IN UPPER LEG OR HIP	☐	☐	ANGINA
☐	☐	PAIN IN LOWER LEG OR KNEE	☐	☐	HEART ATTACK
☐	☐	PAIN IN ANKLE OR FOOT	☐	☐	STROKE
☐	☐	SWELLING/STIFFNESS OF JOINTS	☐	☐	ASTHMA
☐	☐	JAW PAIN	☐	☐	CANCER
☐	☐	TINNITUS (EAR NOISES)	☐	☐	EMPHYSEMA (LUNG DISORDERS)
☐	☐	RAPID HEART BEAT	☐	☐	ARTHRITIS
☐	☐	CHEST PAIN	☐	☐	DIABETES
☐	☐	LOSS OF APPETITE	☐	☐	ULCER
☐	☐	BLOOD DISORDER	☐	☐	BLADDER INFECTION
			☐	☐	COLITIS

3. Please describe the character of your current pain: ☐ Sharp/Shooting ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

4. Did your problem begin: ☐ Due to an accident ☐ Multiple Incidents ☐ Gradually ☐ No Specific Reason ☐ Other _____

5. Describe how your problem began: _____

_____

6. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal Injections ☐ Physical Therapy ☐ Chiropractic ☐ Medicine ☐ X-Ray ☐ Acupuncture ☐ Occupational Therapy ☐ Other _____

7. Have you been treated previously for the same condition? ☐ Yes ☐ No

If yes, by: ☐ MD ☐ Chiropractor ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____

8. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

9. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

10. Do you work? ☐ Yes ☐ No If Yes: ☐ Sitting more than 50% of workday ☐ Light Manual labor ☐ Manual Labor ☐ Heavy Manual Labor ☐ Other _____

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

11. Are your complaints affecting your ability to work or otherwise be active?

☐ No effect ☐ Some physical restrictions (able to perform light duty housework and household tasks)

☐ Need limited assistance with everyday tasks. ☐ Need assistance often

☐ Have a significant inability to function without assistance. ☐ Cannot care for self. ☐ _____

12. Are you currently taking medication? ☐ Yes ☐ No If yes: _____

13. Are you allergic to any drugs or medication? ☐ Yes ☐ No If yes: _____

14. Do you smoke? ☐ Yes ☐ No How many packs/ Day? _____

15. Do you suffer from any type of allergies? ☐ Yes ☐ No If yes: _____

16. Have you had any surgery? ☐ Yes ☐ No If yes: _____

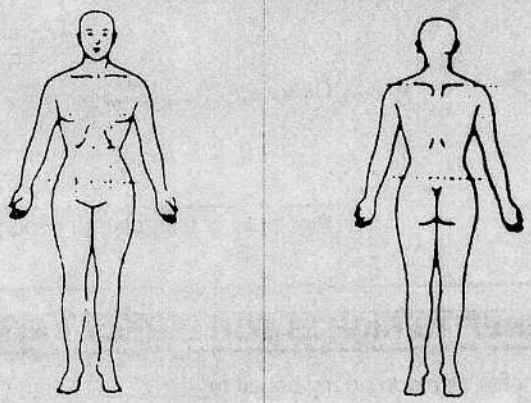
17. Women: Are you pregnant? ☐ Yes ☐ No ☐ Not sure Patient's Initials _____

FAMILY HISTORY

	DIABETES	HEART	KIDNEY	CANCER	BACK	OTHER CONDITIONS
MOTHER	☐	☐	☐	☐	☐	☐ _____
FATHER	☐	☐	☐	☐	☐	☐ _____
BROTHER(S)	☐	☐	☐	☐	☐	☐ _____
SISTER(S)	☐	☐	☐	☐	☐	☐ _____

PAIN / SYMPTOMS PICTURE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN/SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Helping Hands Chiropractic
4800 Baseline Rd., #C-110
Boulder, CO 80303
(303) 494-2800

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ Date_____

Name of Patient (Please Print)

_____ _____

Signature of Patient Signature of Guardian (If Minor)

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to_____
Provider Name

for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient Signature Date