New Patient Application

Welcome to our practice! Please thoroughly complete all questions. Thank you.

Patient Information

Name__________________________________SSN#___________________ Today's Date ____________________

Address____City________________________ State_____________

Zip________________Home phone_________________Cell phone _____________________________________

Date of Birth_____________________ Status: Married Single Divorced Widowed

Email ____

Employer Name______________________________ Employer phone____________________________________

Emergency Contact____________________________Emergency phone____________________________________

Do you have health insurance? _____ Name of Company _________________ Group# ______________________

Subscriber Name/Birth Date ___________________________ Subscriber ID ______________________________

Referred to this office by____

Consent of Treatment of a Minor Child

I hereby authorize the physician in this office and whomever they may designate as assistants administer chiropractic care as deemed necessary to my son/daughter.

Signature___________________________________Date____

Chiropractic Louisville

Health Care Authorization Form

The patient identified above authorized Chiropractic Louisville to use and or disclose protected health information in accordance with the following:

- I give permission to Chiropractic Louisville to use my address, phone numbers, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information. This information may also be used for communication among other health professionals contributing to your care.
- If Chiropractic Louisville contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail or with my family.
- I give Chiropractic Louisville permission to treat me in an open room therapy where other patients are also being treated.
- I give Chiropractic Louisville permission to use and disclose my protected health information in accordance with the directives listed above.

Print Patient Name____

Signature of Patient___________________________ Date_____________________________________

Health Information

What is your major complaint? ____

Any other complaints? ____

How long have you suffered with this condition? ____

On a scale from 0-10 (0 being none and 10 being the worst), what would you rate your pain? ________________

What have you tried to do to get rid of this problem that DID NOT work? ______________________________

____

When your problem is at its worst, how does it make you feel? ____________________________________

____

What type of treatment have you done for this condition? ____

____

What gives you temporary relief? ____

What is the pattern of this problem? (Circle one.) Constant Intermittent Occasional Cyclic

What makes it feel worse? ____

What does it feel like? (**May choose more than one**.) Dull Achy Throbbing Sharp Stabbing Burning

On a scale form 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

Is this condition: Job Related Auto Accident Home injury Fall Other

List any surgical operations and years____

____

Do you have a pacemaker? Yes No

What medications are you currently taking? ____

____

Do you use: Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe____

Have you ever fallen or had other small accidents? Explain. ____

____

Are you pregnant at this time? Yes No When was You Last Period? ______________________________

If yes, how many weeks are you? ____________________

Date of last physical examination__________________ done by______________________

Have you had previous chiropractic treatment? Yes No

If yes, name of Doctor/clinic ____

When was your last treatment? ____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, the questions must be answered carefully as these conditions can affect your overall course of care.

CIRCLE ANY AND ALL OF THE FOLLOWING DISEASES THAT APPLY TO YOU:

			INTAKE
PNEUMONIA	MUMPS	INFLUENZA	
RHEUMATIC FEVER	SMALL POX	PLEURISY	Coffee
POLIO	CHICKEN POX	ARTHRITIS	Tea
TUBERCULOSIS	DIABETES	EPILEPSY	Alcohol
WHOOPING COUGH	CANCER	LUMBAGO	Cigarettes
MEASLES	THYROID	ECZEMA	White sugar

Have you been tested HIV positive? Yes No

CIRCLE ANY OR ALL THAT YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL CODE

low back pain
pain between shoulders
neck pain
arm pain
joint pain/stiffness
walking problems
difficult chewing/clicking jaw
general stiffness
gas/bloating
heartburn
black/bloody stool
colitis

GENERAL CODE

headaches
fatigue
stress
allergies
loss of sleep
fever

GASTRO-INTESTINAL CODE

weight trouble
abdominal cramps
poor/excessive appetite
excessive thirst
vomiting
constipation
hemorrhoids
liver problems
gall bladder problems

GENITO-URINARY CODE

bladder trouble
painful/excessive urination
discolored urine

NERVOUS SYSTEM

cold/tingling extremities
numbness
paralysis
dizziness
forgetfulness
confusion/depression
fainting
convulsions
nervous

EENT

vision problems
dental problems
sore throat
diarrhea
hearing problems
stuffed nose
ear aches

C-V-R CODE

chest pain
short of breath
abnormal blood pressure
irregular heartbeat
heart problems
lung problems
congestion
varicose veins
ankle swelling

FAMILY HISTORY

The following members have the same or similar conditions/problems as I do:

mother
father
brother
sister
spouse
child

All of the above marked conditions are correct and truthful. They are current conditions, or they are a lifetime disease.

Signature ____ Date____________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name ____

Address ____

City ______________________________________ State __________ Zip ______________________

Insurance Company ____________________________ Claim # __________________________________

I hereby instruct the above-named insurance company to pay by check made out to and mailed directly to:

Dr. Greg Thomas
Chiropractic Louisville, PLLC
PO Box 7245
Louisville, KY 40257

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

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, in a manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignement of Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

____ ____________________________________

Signature of Policyholder Dated