Aldridge-Mead Chiropractic, Inc.
130 W. Main Street, Newark, OH 43055
(740) 345-8644 (p) ~ (740) 345-3325 (f)

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Major Accidents Past and Present: _____ When? _____

Serious Illness Past and Present: _____ When? _____

Infectious Diseases Past and Present: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Do you smoke? **Y / N** Amount _____ Do you drink alcoholic beverages **Y / N** Amount _____

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have a history of stroke or heart disease? _____

What is your stress level at work? (1 low – 10 high) _____ What is your stress level in your personal life? (1 low – 10 high) _____

Do you eat balanced meals? _____

Do you have a regular exercise program? _____

Family History: (Include things such as heart disease, diabetes, cancer, stroke and other debilitating diseases.) _____

_____

What is your goal in our office? _____

In the event we would need to communicate your healthcare information, to whom may we do so?
Spouse_____
Children_____
Other_____
No one_____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? **Y / N**

_____ Date: _____
Patient / Guardian Signature

REVIEW OF SYSTEMS

Are you currently experiencing any of the following:

HEAD	EYES	EARS	MENSRUAL/OBSTETRICAL
_____headaches	_____glasses	_____pain	_____pregnant
_____trauma	_____pain	_____ringing/noises	_____menstrual cramps
_____dizziness	_____spots	_____hearing loss	_____breast tenderness/masses
_____fainting	_____double vision/blurred	_____loss of balance	_____difficult deliveries
_____other_____	_____other_____	_____other_____	_____other_____

NOSE AND SINUS	MOUTH AND THROAT	NERVOUS SYSTEM	GENERAL HEALTH
_____pain	_____dentures	_____numbness	_____addiction or substance abuse
_____nosebleeds	_____choking	_____tingling	_____HIV
_____loss of smell	_____gagging	_____nervousness	_____other
_____allergies	_____sore throats	_____coordination	_____
_____drainage	_____difficulty swallowing	_____convulsions	_____
_____other_____	_____other_____	_____other_____	_____

MUSCLES AND JOINTS	GENITAL/URINARY	HEART AND LUNGS	STOMACH AND INTESTINES
_____muscle pain	_____pain	_____asthma	_____pain
_____cramps	_____difficulty urinating	_____chest pain	_____gas
_____joint pain	_____night urination	_____coughing	_____burning
_____joint swelling	_____blood/dark urine	_____sputum	_____vomiting
_____joint stiffness	_____bed-wetting	_____chest noises	_____constipation/diarrhea
_____grinding/popping	_____change in frequency	_____difficult breathing	_____hernia
_____other_____	_____loss of bowel/bladder control	_____high blood pressure	_____appetite problems
		_____other_____	_____other_____

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 care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Aldridge-Mead Chiropractic, Inc. all medical benefits and/or insurance reimbursement (with the exception of Medicare), 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 also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. 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 such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. 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 the 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 extent 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

ACKNOWLEDGEMENT OF PRIVACY POLICIES

I have read and fully understand the above statement. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

PRINT NAME:_____

SIGNATURE: _____ _____

Date