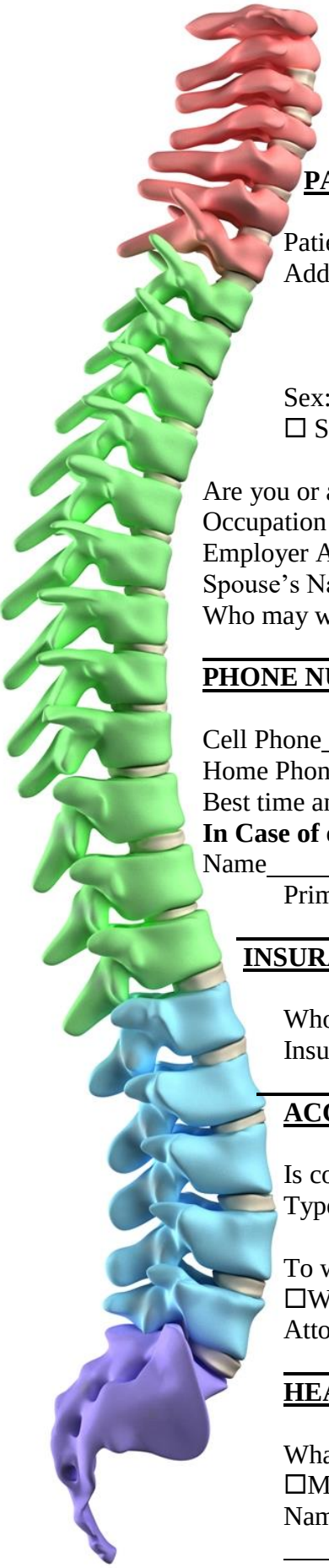
WELCOME…

To Baker-Borski Chiropractic



PATIENT INFORMATION Today's Date _____

Patient Name_____ Patient SS#_____-____-_____
Address_____

_____
City State Zip

Sex: ☐M ☐ F AGE_____ BIRTHDATE_____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other_____

Are you or an immediate family member active military? ☐Yes ☐No
Occupation _____ Employer_____
Employer Address_____Phone_____
Spouse's Name_____Birthdate_____
Who may we thank for referring you?_____

PHONE NUMBERS

Cell Phone_____ Work Phone_____
Home Phone_____ Email Address_____
Best time and place to reach you_____
In Case of emergency, contact:
Name_____Relationship_____
Primary Phone_____Secondary Phone_____

INSURANCE (Medicare recipients only)

Who is responsible for this account? ☐ Myself ☐ Other_____
Insurance Co._____ (please have card ready to present at front desk)

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No If, Yes: Date_____
Type of Accident ☐Auto ☐Work ☐Home ☐Other_____

To who have you made a report of your accident? ☐Auto Insurance ☐Employer
☐Worker Comp. ☐Other_____
Attorney Name (if applicable):_____

HEALTH HISTORY

What treatment have you already received for your condition?
☐Medication ☐Surgery ☐Physical Therapy ☐Chiropractic ☐None ☐Other
Name of other doctors/ treatment facilities that have treated you for your condition_____

_____

Date of last physical exam_____

HEALTH HISTORY (cont.)

S = SELF M = MOTHER F = FATHER S/B = SIBLING

Please indicate which conditions have been experienced by the above by checking the appropriate boxes.

S	M/F	S/B	S	M/F	S/B	S	M/F	S/B
☐	☐	☐ AIDS	☐	☐	☐ Anemia	☐	☐	☐ Arthritis
☐	☐	☐ Asthma	☐	☐	☐ Back pain	☐	☐	☐ Bladder trouble
☐	☐	☐ Bone fracture	☐	☐	☐ Cancer	☐	☐	☐ Chest pain
☐	☐	☐ Concussion	☐	☐	☐ Convulsions	☐	☐	☐ Diabetes
☐	☐	☐ Indigestion	☐	☐	☐ Dislocated joints	☐	☐	☐ Epilepsy
☐	☐	☐ German measles	☐	☐	☐ Headaches	☐	☐	☐ Heart trouble
☐	☐	☐ Hepatitis	☐	☐	☐High blood pressure	☐	☐	☐ HIV / ARC
☐	☐	☐ Kidney disorder	☐	☐	☐ Bowel control loss	☐	☐	☐ Menstrual cramps
☐	☐	☐ Multiple sclerosis	☐	☐	☐Muscular dystrophy	☐	☐	☐ Neck pain
☐	☐	☐ Nervousness	☐	☐	☐ Numbness	☐	☐	☐ Polio
☐	☐	☐ Poor circulation	☐	☐	☐ Rheumatic fever	☐	☐	☐ Reproductive disorder
☐	☐	☐ Rheumatism	☐	☐	☐ Scarlet fever	☐	☐	☐ Serious injury
☐	☐	☐ Sinus trouble	☐	☐	☐ Tuberculosis	☐	☐	☐ Venereal disease

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK HISTORY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day_____
☐Alcohol Drinks/Month_____
☐ Caffeine Cups/Day_____
☐ High Stress Reason_____

Any Children? ☐ Yes ☐ No Date(s) of Birth_____ _____ _____ _____
Are you currently pregnant? ☐ Yes ☐ No Due Date_____

What is your current weight? _____lbs, and height?_____Ft. _____In.

PLEASE NOTE: paperwork must be completed to the best of your ability.

INJURIES / SURGERIES **DESCRIPTION** **DATE(approximate)**

FALLS_____ _____
HEAD INJURIES_____ _____
BROKEN BONES_____ _____
DISLOCATION_____ _____
OTHER_____ _____
SURGERIES_____ _____
_____ _____

ACCIDENT HISTORY (check all that apply, include multiple dates if necessary)

☐ Job_____ _____
☐ Auto_____ _____
☐ Other_____ _____

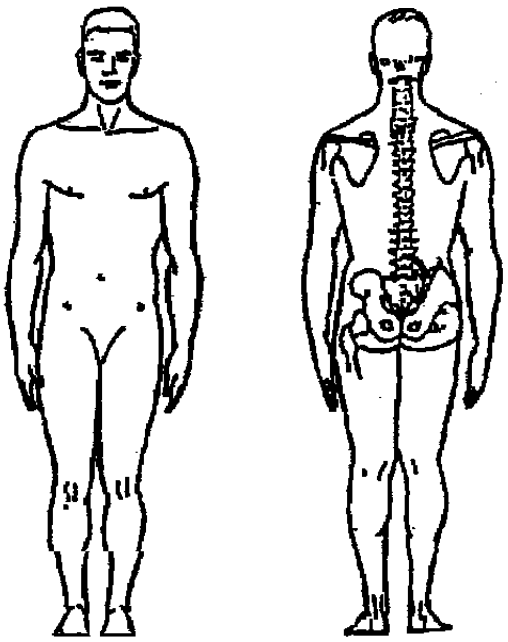
MEDICATIONS/ VITAMINS/ HERBS/ MINERALS (presently taking)

_____
_____
_____

Do you have allergies? ☐Yes ☐No

Number of hours you sleep at night? _____ Sleep on: ☐ Back ☐ Sides ☐ Front
Type, age and condition of mattress?_____
Pillow: ☐ Thick ☐ Medium ☐ Thin Type: ☐ Feather ☐ Foam ☐ Other_____

PATIENT CONDITION



Present major complaints?_____

_____

_____

When did symptoms appear?_____

Is condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Circle and label the areas of your discomfort on the pictures.
Please use the following letters to symbolize the types of pain:

N = Numbness	**P** = Pins and Needles	**B** = Burning
A = Aching	**S** = Stabbing	**T** = Throbbing
D = Dull	**H** = Shooting	**O** = Other

Rate the severity of your pain **1 (least pain) to 10 (severe pain)**

1 2 3 4 5 6 7 8 9 10

How often do you have this pain? _____

Is it constant or does it come and go?_____

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please check the following activities that **AGGRAVATE** your condition:

☐ Bending ☐ Reaching ☐ Straining at stool ☐ Coughing ☐ Sitting ☐ Turning Head
☐ Lifting ☐ Sneezing ☐ Walking ☐ Lying down ☐ Standing

Please check the following activities that **RELIEVE** your condition:

☐ Bending ☐ Sitting ☐ Lifting ☐ Turning Head
☐ Reaching ☐ Standing ☐ Walking ☐ Lying Down

Please check any additional symptoms you may be experiencing:

☐ Blurred Vision	☐ Buzzing in ears	☐ Cold feet
☐ Cold hands	☐ Cold sweats	☐ Concentration loss
☐Confusion	☐Constipation	☐Depression
☐Diarrhea	☐Dizziness	☐Face flushed
☐Fainting	☐Fatigue	☐Fever
☐Head seems heavy	☐Headaches	☐Insomnia
☐Light bothers eyes	☐Loss of balance	☐Loss of smell
☐Loss of taste	☐Low resistance to colds	☐Muscle jerking
☐Numbness in fingers	☐Numbness in toes	☐Pins & Needles in arms
☐Pins & needles in legs	☐Ringing in ears	☐Shortness of breath
☐Stiff neck	☐Stomach upset	☐ Other_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____

SIGNATURE OF PATIENT (or parent if a minor) *DATE*

FINANCIAL PAYMENT AGREEMENT:

Cash Patients: Payment is expected at the time services are rendered.

Flex Spending Plans/ Medical Savings Accounts: Patients utilizing their flex spending plans/ medical savings accounts are to pay at the time services are rendered. We will gladly print a statement for you to submit to be reimbursed by your flex spending plans.

Major Medical Insurance Patients: All major medical patients are responsible to pay for all charges at the time services are rendered. If you wish to submit claims to your insurance company you may do so by asking the front desk for a "Super Bill" after each visit and submitting to your insurance personally. Insurance benefits are a contract between you and your insurance carrier please read your plan booklet for more information on your specific insurance benefits.

Medicare Patients: Patients need to understand that their insurance is a contract between themselves and the insurance carrier. We are not a part of that relationship and at this time only provide a service of submitting claims one time for patients. Each year Medicare determines how much we can charge for chiropractic adjustments. Medicare also does not pay for any examinations and x-rays, but requires that these services are performed on all patients. If you have a secondary insurance they may reimburse you for these charges. Patients are expected to pay at the time they receive their service. Your claims will be submitted weekly and you will receive reimbursement from the insurance company. **Medicaid/Badger Care:** Unfortunately we do not accept patients under this program at this time.

Personal Injury (including motor vehicle accidents): Patients are expected to pay for services at the time they are rendered. Your claims will be submitted weekly and you will receive reimbursement from the insurance company and/or as a result of litigation. The consequences of inaccurate or incomplete information given to us will only delay payment to you.

Worker's Compensation: By law, we will receive payment from the WC insurance carrier. However, if your claim and subsequent appeals are denied, your total charges are due immediately. We will not act on your behalf but only provide the services necessary to return you to as close to pre-injury status as is possible. Any litigation as a result of denial does not release you from responsibility for paying for your charges at our office in full at the time the claim is denied.

Please remember that you are responsible for full payment of your account regardless of insurance coverage. An insurance policy is a contract strictly between the insurance company and you, the policyholder.

If you discontinue care prior to the completion of your prescribed care plan, your bill will be due, IN FULL, within 30 days. If the account is not paid within 60 days of the date of services, and no financial arrangement has been made, your account will be sent to collections.

We accept cash, check, credit/debit cards. Please note a returned check due to insufficient funds will have a $30.00 reprocessing fee due to our office. Also, credit card transactions will also include at 3.75% processing fee.

I have read and understand the full office policy for payment addendum as given to me. All my questions have been fully answered. I hereby authorize payments of benefits directly to the provider of benefits due to me for services rendered. If payment for services rendered is not received within 30 days of filing, I am responsible for paying all charges at that time in full. This applies also to Medicare and secondary/supplemental insurance if they deny payment as well.

If I have been involved in a work-related injury and my claim is denied by my employer's worker's compensation carrier, I accept full responsibility for my care and account and understand payment is due in full immediately.

If I have been involved in an automobile accident or other personal injury I accept full financial responsibility for my care at the time of service. I understand that it is my responsibility to collect from the insurance company independent of the final deposition of my case.

MISSED APPOINTMENT POLICY

We ask **24 HOURS'** notice for any changes in appointments. There is a **$20** charge for appointments missed or cancelled with less than 24 hours' notice, (excepting any unforeseen emergency). This must be paid by or before the next appointment.

Patient Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____