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PRENTICE CHIROPRACTIC
BEND, OREGON

Today's Date _____

Last Name _____ First Name _____ M.I._____

Street Address _____

City _____ State ____ Zip Code _____

Date of Birth _____ Age _____ Marital Status: S M W No. Children _____

Mobile Phone _____ Home Phone _____

Email _____

Employer _____ Occupation _____

Emergency Contact: Full Name _____

Phone Number _____ Relationship _____

How did you hear about us? _____

Were you injured on the job? No Yes When? _____

Were you injured in an auto accident? No Yes When? _____

Describe your present problem _____

Have you ever had this problem before? No Yes When? _____

When did the problem begin? _____

Other Conditions: _____

Date of Last Exam: _____ Are you pregnant? _____

Reason for Seeking Care _____

What are your goals for care? _____

In general would you say your health is: Poor Fair Good Very Good

Please check the following habits (H = Heavy; M = Moderate; L = Light; N = N/A)

Tobacco H M L N **Alcohol** H M L N **Caffeine** H M L N **Drugs** H M L N

Overeating H M L N

Please indicate if you have a serious or chronic medical condition:

Neck pain Migraines Asthma Diabetes Heart Disease Cancer Fatigue Thyroid Allergies Headaches Dizziness Arm pain Numbness Chest Pain Back Pain Ulcers Colitis Sciatica Arthritis Low Bld. Pressure High Bld. Pressure Gout High Cholesterol Anxiety Depression Nervousness PTSD Joint Swelling Freq. Urination Constipation Diarrhea Sinus Problems Neck Tension Digestive Disorders Nose Bleeds Pain Between Shoulders Anemia Hot Flashes Bursitis Crohn's Disease Sleeping Problems Fertility Problems IBS ADD/ADHD

Please list any known food allergies

_____

_____

Other conditions, please specify

_____

_____

Any other health concerns? _____

Prescriptions _____

Have you been treated for any health condition by a physician in the last year? If so, please describe:

_____

List your top 3 health complaints/concerns

1 . _____

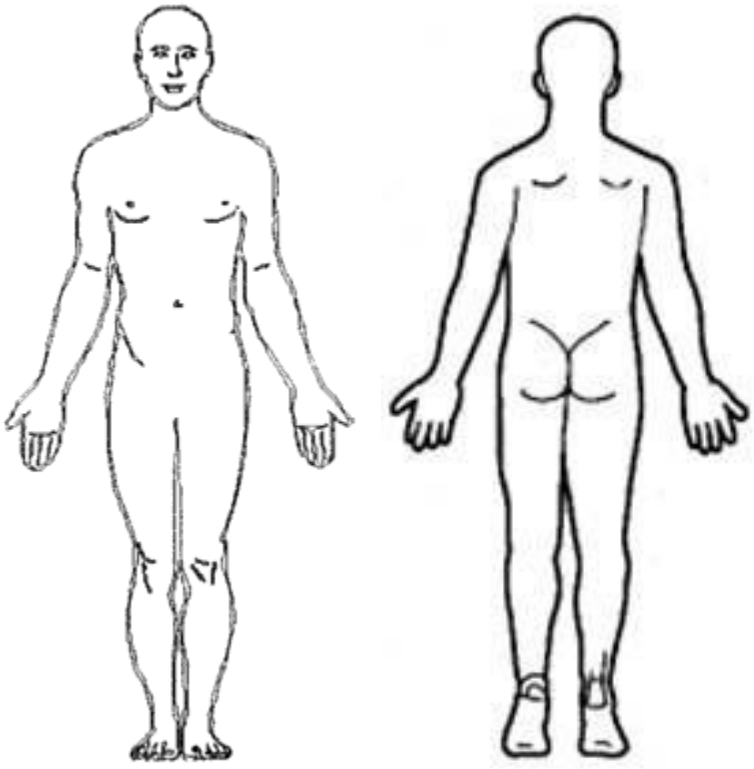
2 . _____

3 . _____

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area using the abbreviations on the diagram below, along with the pain rating from the scale.

Scale of 1 -10 with 10 being the worst.

SP = Sharp Pain DP = Dull Pain B = Burning S = Stinging N = Numbness T = Tingling ST = Stiffness A = Abnormal Sensation



Prentice Chiropractic

Patient Financial Policy

Thank you for choosing us for your health care needs. We are committed to providing you with quality, affordable care. We ask all patients to review and sign this policy.

Insurance Verification: Prentice Chiropractic is contracted with several insurance plans. We will verify your insurance coverage as a courtesy. Quotes received from your insurance company represent an estimate only and not a guarantee of payment. If you have any questions regarding your plan's specific benefits, please contact your insurance carrier.

Insurance Billing: We will bill your insurance as a courtesy, according to the coverage presented at the time of service. All benefits are assigned and paid to Prentice Chiropractic. **Per insurance carrier agreements, copayments, coinsurances, deductibles, and non covered services are due at the time of service.** Payment in full is required at each visit you are adjusted. Upon request, we can provide you with a superbill to submit to your insurance for reimbursement.

Patient Balance: After receiving payment from your insurance company, you will receive a statement for any balance due. If you have any questions regarding the processing of your claims, please contact your insurance company. We expect payment in full within 30 days. If you cannot pay your balance in full, please communicate with out office to arrange for a payment plan.

Past Due Balances: Failure to pay your account may result in a collections agency assignment.

I have read, understood, and accept this financial agreement.

Patient/Guardian Signature: _____ Date: _____

Insurance Information

Insurance Company: _____

Policy Holder/Insured:_____

Policy Number: _____

Group #: _____

Group Name: _____

Policy Holder's (if different from patient): _____

Policy Holder's Date of Birth (if different from patient): _____

Policy Holder's Relationship to Patient: _____

For Medical Staff only:

Chiropractic Manipulation

Copay _____ Coinsurance _____ Deductible _____ Applies? **Yes** **No**

Limit _____

Physical Therapy

Copay _____ Coinsurance _____ Deductible _____ Applies? **Yes** **No**

Limit _____

X-Rays

Copay _____ Coinsurance _____ Deductible _____ Applies? **Yes** **No**

Blood pressure
Systolic: Diastolic:

Pulse: bpm
Height:
Weight:

Cervical ROM:	Thoraco-Lumbar ROM:	Kemps:	FCT:	SLR:
F:	F:	L:	N:	L:
E:	E:	R:	L:	R:
LR:	LF:		R:	
RR:	RF:			
LF:				
RF:				

99212 (Office Visit)

99202 (Expanded Exam)

99211 (EP routine reexam)

72020 (Single view)

72040 (Cervical- 2-3 views) - M99.01 M54.2

72050 (Cervical- 4 views) - M99.01 M54.2

72070 (Thoracic ltd. 2 views) - M99.06 M54.6

72080 (Thoracolumbar 2 views) - M99.03 M54.59

98940 (1-2 region) - M99.01 M54.2

98941 (3-4 region) - M99.01 M54.2 M99.02 M54.6 M99.03 M54.59

97140 (Man. therapies) **97012** (Mechanical Traction)

Re Exam

Date: _____

Cervical ROM:	Thoraco-Lumbar ROM:	Kemps:	FCT:	SLR:
F:	F:	L:	N:	L:
E:	E:	R:	L:	R:
LR:	LF:		R:	
RR:	RF:			
LF:				
RF:				

Re Exam

Date: _____

Cervical ROM:	Thoraco-Lumbar ROM:	Kemps:	FCT:	SLR:
F:	F:	L:	N:	L:
E:	E:	R:	L:	R:
LR:	LF:		R:	
RR:	RF:			
LF:				
RF:				