Dentinger Chiropractic and Wellness PLLC
DBA Connect Chiropractic
919-307-9610

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F / M / MTF / FTM

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None

Relationship Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Partnered How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Primary Phone (_____) _____May we leave a message? ☐ YES ☐ NO Phone (_____) _____

EMAIL ADDRESS _____ Can we contact you via Email ☐ YES ☐ NO

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

DEMOGRAPHICS – Please circle your answers
*Preferred Language : English / Spanish / Dutch / French / German / Greek / Italian / Japanese / Portuguese / Russian / Decline
*Race: American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian /Pacific Island / Decline
*Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

*Smoking Status: Current Every Day smoker / Current Some Day Smoker / Former Smoker / Never Smoker / Unknown
**Appointment Reminders by Email: _____Yes _____No Reminder Needed

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

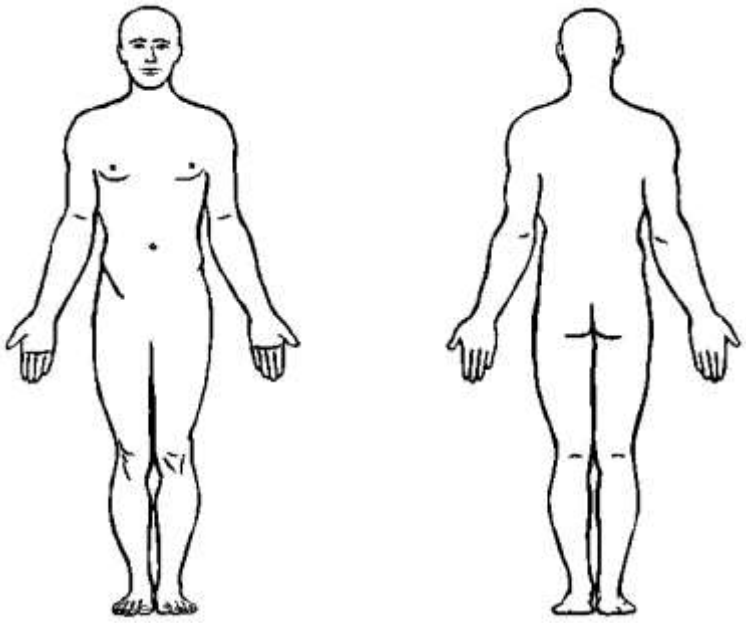
_____

(1) Please place a line through the scale below at the point that best describes your pain.

(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Please indicate with an X on the drawing where you are feeling pain or having problems.



Approximately, when did your injury or condition occur?

___/___/____

Describe your condition, symptoms, or the purpose of this appointment:

_____

_____

_____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO

If yes, when and describe:

_____

_____

_____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

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Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Date of last physical examination? _____

What surgery/Serious Illnesses/Conditions have you had?

_____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking?

_____ Dosage?_____

_____ Dosage?_____

_____ Dosage?_____

_____ Dosage?_____

Do you have any Allergies? _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

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INSURANCE POLICIES

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I recognize that Dentinger Chiropractic and Wellness PLLC (DBA Connect Chiropractic) is an out of network provider and does not file insurance. Connect Chiropractic will happily provide any receipts that I may need to submit to my insurance company within reason.

APPOINTMENT POLICIES

I understand that I am responsible for keeping track of my own appointment schedule and that it is expected I will be on time to my appointments. I understand the following procedures:

- Payment for service is expected at the time of service.
- If I believe I have a financial hardship I will let the office know and everything possible will be done to make it possible for me to receive the care I need.
- There is a 24 hour cancellation policy. It is my responsibility to let the office know 24 hours in advance if I will not be able to make my appointment. This information can be left via voicemail at (919)307-9610 or emailed to drcate@chiropracticforwomen.com.
- If I fail to let the office know 24 hours in advance then I will be charged for my missed appointment. (Connect Chiropractic understands that emergencies may happen, and will be understanding in these cases.)
- The cost of my care and expectations of my care will be explained to me prior to receiving care.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____