Confidential Patient Questionnaire

Personal Information

Name: ____________________ Date: ____________
Home Phone: ____________ Cell: ____________ Work: ____________
Address (w/ City, State & Zip): ____________________
Age: ______ DoB: __________ Marital Status: _M _S _D SSN: ____________
Occupation: ____________________ Employer Name: ____________
Employer Address: ____________________
Name of Spouse: ________________ Employer of Spouse: ____________
Emergency Contact Name: ____________ Relationship to you: ____________
Contact Phone: ____________ Patient Signature: ____________________

Financial & Insurance Information

Name of Party Responsible for Payment: ____________________
Social Security #: ____________ Driver's License #: ____________
Do you have Insurance: _Y _N Insurance Company: ____________________

Patient Insurance	Policy #	Group Plan #	Medicare #
Spouse's Insurance	Policy #	Group Plan #	Medicare #
Worker's Compensation Carrier		Other	

Current Complaint

Describe Current Complaint (Reason for Visit): ____________________

At the onset of this complaint, were you under any medically prescribed disabilities or self-imposed restrictions: _Y _N If Yes, Describe: ____________________

Other Medical Care

List any other doctors seen for this condition (if possible, include address).

Doctor Name	Address
Doctor Name	Address
Doctor Name	Address

Did you go to the Hospital: _Y _N
If Yes, how did you get to the hospital: __ Ambulance / Other ____________
If admitted, how long did you stay: ____________________
What type of treatment did you receive? (Include X-rays, recommendations, etc.)

Medication prescribed: _Y _N List name(s) of medication: ____________________

Confidential Patient Questionnaire - Continued.

General Health History

_ Cancer
_ Epilepsy
_ Digestive Problems
_ Asthma
_ Tuberculosis
_ Dizziness
_ Rheumatism
_ Hepatitis
_ Hypertension
_ Convulsions
_ Venereal Disease
_ Anemia
_ Numbness
_ Diabetes
_ Concussion
_ Polio
_ Arthritis
_ Allergies
_ Back Problems
_ Tingling
_ Migraine
_ Heart Attack
_ Multiple Sclerosis
_ Sinus History
_ Neuritis
_ Muscular Dystrophy
_ Rheumatic / Scarlet Fever

If Female, are you pregnant: _ Y _ N _ Not Certain

Any prior hospitalizations or surgeries? (Please list) ________________________________

____

____

Present Complaints

_ Headache
_ Neck Pain/Stiff
_ Chest Pain
_ Concentration Loss
_ Short of Breath
_ Diarrhea
_ Numbness
_ Memory Loss
_ Digestive Trouble
_ Vomiting
_ Upper Back Pain/Stiff
_ Swelling
_ Anxiety
_ Mid Back Pain/Stiff
_ Cold hands
_ Low Back Pain/Stiff
_ Depression
_ Cold Feet
_ Ringing in Ears
_ Right/Left Shoulder Pain
_ Insomnia
_ Loss of Balance
_ Right/Left Arm Pain
_ Fatigue
_ Loss of Smell/Taste
_ Flushed Face
_ Bleeding
_ Right/Left Leg Pain
_ Pale Face
_ Broken Bones
_ Pain Behind Eyes
_ Pins & Needles Arms/Legs
_ Sinus Trouble
_ Alcohol Intolerance
_ Vision Problems
_ Neuritis
_ Fainting
_ Excess Perspiration
_ Constipation
_ Eyes Sensitive to Light
_ Nausea
_ Dizziness
_ Loss of Consciousness
_ Irritable
_ Jaw Pain
_ Cuts
_ Neck Motion Restricted
_ Head Feels Heavy
_ Bruises
_ Nervousness
_ Heart Palpitations
_ Other (Please List): ____

____

Radiation of Pain into: _ Rt. Arm _ Left Arm _ Both _ Rt. Leg _Left Leg _Both

Pain Aggravated Upon: _Walking _ Sitting _ Standing _ Bending _ Riding _ Lying Down

Confidential Patient Questionnaire - Continued.

Pre-Existing Conditions

Have you sought care for a health condition in the past year: _Y _N Past 2 years: _Y _N

If yes, what condition: ____

Was treatment administered: _Y _N Describe____________________________________

Do you take Medication: _Y _N Describe____________________________________

Complete this section if your visit is due to an accident

Accident History

Type of accident: _Auto _Worker's Comp _Fall _Other________________________

Date of accident: ______________ Brief description of accident: ____________________

____

____

Auto Accident Section

Where seat belts worn: _Y _N _Shoulder _Lap

Seat position in vehicle: ____

If vehicle had headrests, describe position compared to your head:

_ Top of headrest aligned with top of head

_ Top of headrest aligned with middle of head

_ Top of headrest aligned with bottom of head

Briefly describe the collision impact:

_ Head on collision _ Left side impact _ Right side impact _ Rear end collision

List any parts of your body that made contact with vehicle parts: ____________________

____

Were you braced for impact: _Y _N

Were brakes applied: _Y _N

Were you looking up into rear view mirror: _Y _N

Were you looking at outside door mirror: _Y _N

Was your vehicle stopped: _Y _N

Any previous motor vehicle accidents: _Y _N If yes, describe: ____________________

____

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____

If yes, was treatment rendered previously: _Y _N If yes, describe: ________________

____

____

____

Financial Information:

Welcome to Bernd Chiropractic.
We would like our patients to understand our fees and be satisfied that they are reasonable and equitable.
PAYMENT IS DUE AT THE TIME OF EACH VISIT, AND IS RENDERED AS YOU LEAVE.
We accept Master Card and Visa and if necessary we can take a post date check. If for some reason you cannot make payment at the time of your appointment, please discuss the matter with our receptionist (BEFORE BEING SEEN) so that a mutually satisfactory agreement can be arranged.

How we bill your insurance:

We wish to stress that the financial responsibility for services rendered rests with the patient or their family, regardless of insurance coverage. As a courtesy we will bill your insurance company for you. Your insurance policy is a contract between you and your insurance provider. We cannot guarantee payment of your claim. if the claim is not paid, the insurance provider should explain why it was denied, and you are responsible for payment of previous services rendered.

Worker's Compensation Insurance:

Chiropractic services may be covered by Workman's Compensation Law, and you should be covered 100%, as long as you have reported the injury to your employer and your employer is covered by Worker's Compensation Insurance. Under current Workman's Compensation Laws your claim must be authorized or denied within one working day after having filed. Please check with your employer regarding any other requirements of the the company's worker's compensation policy.

Medicare:

Our Office does not accept assignment for Medicare. The patient is required to pay for the visit at the time of service. As a courtesy, we will bill Medicare for you and you will be reimbursed by Medicare for services rendered. Medicare will typically pay for 12 adjustments per year.

Services **NOT** covered by Medicare include chiropractic X-rays, supplements, therapy modalities and supports. You will be expected to pay for these services when rendered or purchased.

Missed Appointments:

We require 24 hours notice when canceling or rescheduling an appointment. A $25 fee may be assessed if appointments are missed (or rescheduled) without the proper notice.

PATIENT SIGNATURE ____________________ DATE ____________

Personal Injury Insurance Verification

Patient's Name: ____

Insured's Name (if not Patient): ______________________________________

Name of Insurance Company: ___________________________________

Billing address: ______________________________

____

Phone #: ___________________________________

Agent's Name: ______________________________ Phone #: _______________________

Adjuster's Name: ____________________________ Phone #: _______________________

Policy #: ___________________________________ Claim #: _______________________

Do you have med-pay coverage: _Y _N How Much: _______________________

How much has been used: ____________________ Date of accident: __________________

Have you filed a claim with your Insurance Company: _Y _N

Information on Other Party:

Name: ____

Insurance Company: ______________________________________

Phone #: ___________________________________

Billing address: ______________________________

____

Agent's Name: ______________________________ Phone #: _______________________

Policy #: ___________________________________ Claim #: _______________________

Will bills be paid on an ongoing basis or upon settlement: _______________________

What is the liability limit: ______________________________________

Do you have a Private Health Insurance Carrier: ____________________________

Billing Address (for sending statement): ______________________________

____

Attorney's Name: ____________________________ Address: _______________________

Phone #: ___________________________________ _______________________