Kent Chiropractic Clinic Patient Information

Patient Information

Legal First Name	Legal Last Name	M.I.	Preferre	d First Name
Permanent Address	Apt # City		State	Zip
Home Phone#	Cell Phone#	Work Phone#	Gender	Birth Date
Marital Status	Email Address			Today's Date
Emergency Contact I	<u>nformation</u>			
Contact Name		Phone #	Relation	ship to Patient
Employment Informa	ation			
Occupation	Employer's Name			
•				
Medical Insurance In	nformation (IF OTHER	THAN PATIENT)		
		* 		
Policy Holder's Name	Policy Holder	's Relationship to Patien	t Policy H	older's Date of Birth
Policy Holder's Address	City		State	Zip

Kent Chiropractic Clinic Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Kent Chiropractic.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition any remaining balance on your account will be billed to you.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- Co-payments are due before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Kent Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Kent Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me and not paid for by insurance are charged directly to me and that I am personally responsible for payment. If payment is not received in 30 days after being billed by this office, an 8% interest fee (compounded annually) will be added to your account.

Responsible Party's Signature		· · ·	- Date	<u></u>

Kent Chiropractic Clinic Consent for Treatment

Patient Consent for Treatment

- 1. I voluntarily consent to any and all health care treatment and diagnostic procedure provided by Kent Chiropractic Clinic. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of treatments or examinations by Kent Chiropractic Clinic.
- 2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and therapies consistent with Kent Chiropractic Clinic's Notice of Privacy Practices.
- 3. Lauthorize payment of medical benefits to Kent Chiropractic Clinic for services rendered.

itient or Authorized Person's Sig	nature	Date

10/14

Kent Chiropractic Clinic Personal Injury - Patient Info Form

Name:	File #:	Date:	
Date of Accident:	Time:	AM/PM	
Driver of Car:	4 A 48	seated:	
Car Owner:		Auto:	
What was the approximate damage done to the			
Visibility at time of accident: [] poor [] fair [Road conditions at time of accident: [] Describe:	icy [] rainy and wet	[] clear [] dark [] other:	
Where was the car struck: [] right [] left []	rear []front []side []ot	her:	
Type of accident: [] head-on collision [] bead-on collision [] finan-collision:	road-side collision ront impact, rear-ended car in	front	
Describe in your own words what happened to y		- department of the second of	
Did you see the accident coming? Yes/No Did you brace yourself for Impact? Yes/No Were you wearing a seat belt with a shoulder had Did the car have headrests? Yes/No If yes, what was the position of the head if the position at the position of the head in the	drest compared to your head f head ad neck he accident? Yes/No he accident? Yes/No i were going?mph ent travelling?mpi [] body straight in sittin [] body rotated left/right	h g position at	
As a result of the accident you were: [] rendered unconscious [] dazed, circumstances vague [] other Could you move all parts of your body? Yes/No If no, what body parts and why?			
Were you able to get out of the car and walk un If no, why not?	aided? Yes/No		
Did you get bleeding cuts or bruises? Yes/No	•		
If yes, what bruises did you get from th	e accident?		

Later that day:		Night:		
The following day:		•		
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[] Neck pain/Stiffness			old hands	
[] Mid back pain	[] Loss of memory		old Feet	
[] Low back pain	[] Fatigue		larrhea	
[] Eyes sensitive to light			onstipation	
[] Pain behind eyes	[]Shortness of breath		hest pain	
	[] Irritability		ervousness	
[] Fainting	Depression	110	old sweats	
[]Ringing/buzzing in ears			nxiousness	
[]Loss of Balance	[] Numbness in toes		ther:	
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if yes, Full time off work: Part time off work:		* *************************************	^{,,} U	
Part time off work:	cince accident		W	
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Patient Health Questionnaire ChircCare of Minnesota, Inc.

ChiroCare Use Only nev 4/19/89

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a. If you have received treatment in the past for the same or similar symptoms, who did you see? Other Chiropractor Other Other Other Other Othe		•	@ Offier	
the same or similar symptoms, who did you see? © Other Chiropractor © Physical Therapist 11. What is your occupation? ① Professional/Executive ② White Collar/Secretarial ② Homensker ② Other ② Tradesperson ② Self-employed ③ Off work student, what is your current work status? ② Part-time, ② Self-employed ③ Off work ③ Unemployed ③ Other 12. What do you hope to get from your visit/treatment (select all that apply): ③ Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again ② Resume/increase activity ④ Learn how to take care of this on my own ⑥	• • •	® Yes Ø No		
The same or similar symptoms, who did you see? © Other Chiropractor © Physical Therapist 11. What is your occupation? © Professional/Executive © Understand © Homensker © Other a. If you are not retired, a homensker, or a student, what is your current work status? © Pârt-time, © Self-employed © Other 12. What do you hope to get from your visit/treatment (select all that apply): ① Reduce symptoms © Explanation of condition/treatment © How to prevent this from occurring again of the care of this on my own ©	a. If you have received treatment in the past for	O This Office	Medical Doctor	(6) Other
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student, what is your current work status?	a. If you are not retired, a homemaker, or a	(f) Eulkima	A) Salf animious	A OF west
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Reduce symptoms Sexplanation of condition/treatment	2. What do you hope to get from your visitiresten	• • •		Marian Marian
Resume/increase activity			A Linear by promount thin fam.	or occupation with
	Resume/increase activity	e care of this on my own		
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Patient Health Questionnaire - page 2 ChiroCare of Minnecola, Inc.

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	type of regular exercise do you	perform?	• ONone ØLig	ıht	Moderate	
What	is your height and weight?			····	·	4 Suelitious
			Height		Weight	lbs.
For e	ach of the conditions listed beld presently have a condition list	w. nlace	Feet Inche			
If you	presently have a condition list	ed below,	place a check in the Present	you naye :olumn.	e had the cond	lition in the past.
Past	Present	Past	Present	•	Present	
O	O Headaches	O	O High Blood Pressure	Casar		
0	O Neck Pain	0	O Heart Attack	Ö	O Diabete: O Excessive	
Ŏ	O Upper Back Pain	0	O Chest Pains	, 0		
Ö	O Mid Back Pain	0	O Stroke	. 0	 Frequent 	t Urination
0	O Low Back Pain	0	O Angina	0	O Smoking	/Use Tobacco Product
ο.	O Shoulder Pain		·	Õ		ohol Dependence
0.		0	O Kidney Stones	7.	~ ora@irac	oun nebelidatics
ò	O Elbow/Upper Arm Pain	Ö	O Kidney Disorders	0	O Allergies	
	O Wrist Paln	0	O Bladder Infection	0	O Depress	ion
0	O Hand Pain	0	O Painful Urination	0		Chupus Comment
0	O Hip/Upper Leg Pain	0	O Loss of Bladder Control	Ö	O Epilepsy	a method
Ō	O Knee/Lower Leg Pain	0	O Prostate Problems	0	O Dermaiii	is/Eczeme/Rash
0	O Ankle/Foot Pain	0	O Abnormal Weight Gain/Loss	0	O HIV/AID:	Z more tricki resert
_		ō	○ Loss of Appetite			
0	O Jaw Pain	ŏ	O Abdominal Pain	Fel	neles Only	· 10
0	O Joint Swelling/Stiffness			0	O Birth Cor	trol Pills
Ō.	O Arthritis	Ö	O Ulcer	0		l Replacement
ŏ	Rheumatoid Arthritis	Ö	○ Hepatitis	0	O Pregnan	in a confinencial states.
0	C RECORDED ATTEMES	0	O Liver/Gall Bladder Disorder	0	0	•
0	O General Fatigue	. 0	O Cancer		-	•• . • •
. 0	O Muscular Ingoordination	Ō	O Tumor		er Health Pro	blems/issues
Q	O Visual Disturbances	_		0	Q	
0	O Dizziness	0	O Asthma	0	¢.	
	and the second of the second o	0	O Chronic Sinusitis	0	Ο.	
ndica	to if an immediate family membe	or has ha	d any of the following			Q
OR	eumatoid Arthritis O Heart Pro	objems String M	A 200 a .		•	
			O Diabetes O Cancer	O	Lupus O_	
ist al	prescription and over-the-cour	itar madi		,		•
		INDE HERSTER	estivies, quar numitional/nerda/	Supplen	nents you are	taking:
			7-7-1-1-1			
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