New Patient Application

Welcome to our practice! Please thoroughly complete all questions. Thank you.

Patient Information

Name_____SSN#_____ Today's Date _____

Address_____City_____ State_____

Zip_____Home phone_____Cell phone _____

Date of Birth_____ Status: Married Single Divorced Widowed

Email _____

Employer Name_____ Employer phone_____

Emergency Contact_____Emergency phone_____

Do you have health insurance? _____ Name of Company _____ Group# _____

Subscriber Name/Birth Date _____ Subscriber ID _____

Referred to this office by_____

Consent of Treatment of a Minor Child

I hereby authorize the physician in this office and whomever they may designate as assistants administer chiropractic care as deemed necessary to my son/daughter.

Signature_____Date_____

Chiropractic Louisville

Health Care Authorization Form

The patient identified above authorized Chiropractic Louisville to use and or disclose protected health information in accordance with the following:

- I give permission to Chiropractic Louisville to use my address, phone numbers, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information. This information may also be used for communication among other health professionals contributing to your care.
- If Chiropractic Louisville contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail or with my family.
- I give Chiropractic Louisville permission to treat me in an open room therapy where other patients are also being treated.
- I give Chiropractic Louisville permission to use and disclose my protected health information in accordance with the directives listed above.

Print Patient Name_____

Signature of Patient_____ Date_____

Health Information

What is your major complaint? _____

Any other complaints? _____

How long have you suffered with this condition? _____

On a scale from 0-10 (0 being none and 10 being the worst), what would you rate your pain? _____

What have you tried to do to get rid of this problem that DID NOT work? _____

_____

When your problem is at its worst, how does it make you feel? _____

_____

What type of treatment have you done for this condition? _____

_____

What gives you temporary relief? _____

What is the pattern of this problem? (Circle one.) Constant Intermittent Occasional Cyclic

What makes it feel worse? _____

What does it feel like? (**May choose more than one**.) Dull Achy Throbbing Sharp Stabbing Burning

On a scale form 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

Is this condition: Job Related Auto Accident Home injury Fall Other

List any surgical operations and years_____

_____

Do you have a pacemaker? Yes No

What medications are you currently taking? _____

_____

Do you use: Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe_____

Have you ever fallen or had other small accidents? Explain. _____

_____

Are you pregnant at this time? Yes No When was You Last Period? _____

If yes, how many weeks are you? _____

Date of last physical examination_____ done by_____

Have you had previous chiropractic treatment? Yes No

If yes, name of Doctor/clinic _____

When was your last treatment? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, the questions must be answered carefully as these conditions can affect your overall course of care.

CIRCLE ANY AND ALL OF THE FOLLOWING DISEASES THAT APPLY TO YOU:

PNEUMONIA	MUMPS	INFLUENZA	**INTAKE**
RHEUMATIC FEVER	SMALL POX	PLEURISY	Coffee
POLIO	CHICKEN POX	ARTHRITIS	Tea
TUBERCULOSIS	DIABETES	EPILEPSY	Alcohol
WHOOPING COUGH	CANCER	LUMBAGO	Cigarettes
MEASLES	THYROID	ECZEMA	White sugar

Have you been tested HIV positive? Yes No

CIRCLE ANY OR ALL THAT YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL CODE
low back pain
pain between shoulders
neck pain
arm pain
joint pain/stiffness
walking problems
difficult chewing/clicking jaw
general stiffness
gas/bloating
heartburn
black/bloody stool
colitis

GENERAL CODE
headaches
fatigue
stress
allergies
loss of sleep
fever

GASTRO-INTESTINAL CODE
weight trouble
abdominal cramps
poor/excessive appetite
excessive thirst
vomiting
constipation
hemorrhoids
liver problems
gall bladder problems

GENITO-URINARY CODE
bladder trouble
painful/excessive urination
discolored urine

NERVOUS SYSTEM
cold/tingling extremities
numbness
paralysis
dizziness
forgetfulness
confusion/depression
fainting
convulsions
nervous

EENT
vision problems
dental problems
sore throat
diarrhea
hearing problems
stuffed nose
ear aches

C-V-R CODE
chest pain
short of breath
abnormal blood pressure
irregular heartbeat
heart problems
lung problems
congestion
varicose veins
ankle swelling

FAMILY HISTORY
The following members have the same or similar conditions/problems as I do:
mother
father
brother
sister
spouse
child

All of the above marked conditions are correct and truthful. They are current conditions, or they are a lifetime disease.

Signature _____ Date_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name _____

Address _____

City _____ State _____ Zip _____

Insurance Company _____ Claim # _____

I hereby instruct the above-named insurance company to pay by check made out to and mailed directly to:

Dr. Greg Thomas
Chiropractic Louisville, PLLC
PO Box 7245
Louisville, KY 40257

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignement of Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

_____ _____

Signature of Policyholder Dated