Wellspring Chiropractic Center

727 E. Canal Street, Nelsonville, Ohio 45764

CONFIDENTAL PATIENT INFORMATION: DATE:_____/_____/20_____

Name: Last _____ First _____ MI ____ Home Phone: (____)_____

Address: _____ City _____ State _____ ZIP _____

Cell Phone: (____)_____ Email Address _____

Social Security # _____ Age _____ Birth Date ___/___/___ Sex _____ Marital Status _____

Name of Spouse_____ Employer _____

Your Employer _____City/State_____Wk Phone (____)_____

Type of Work _____

Name/Relationship of Emergency Contact _____ Phone (____)_____

Who referred you to our office? _____

Do you have insurance you'd like for us to file for you? _____ Name of Insurance _____

PAYMENT/INSURANCE INFORMATION:

Who is responsible for your bill? __Self (Cash) __Health Insurance __Worker's Comp __Auto Insurance __Medicare __Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Have you additional (secondary) insurance? __Yes __NO

Health Insurance Carrier: _____ Insurance Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

WORKER'S COMPENSATION INJURY / AUTO / PERSONAL INJURY:

Have you filed an injury report with your employer? __Yes __No Date: ____/____/____

Is your current injury a result of an auto accident? __Yes __No Date: ____/____/____

Patient Signature: _____ Date: _____

PAST HEALTH HISTORY:

Have you seen a Chiropractor before? __Yes __No Name:_____ Date:_____

Major Surgery**:** Appendectomy / Tonsillectomy / Gall Bladder / Back Surgery / Other _____

Broken Bones: _____

Major Accidents or Falls: _____

Hospitalizations: (other than above) _____

Below is a list of conditions relative to your overall health status. Although they may seem unrelated to the purpose of your appointment, such conditions may affect your overall diagnosis and treatment. Please consider these conditions carefully and explain the details of any conditions for which you have checked "yes".

MUSCLE/JOINT:
Have you had any problems with the joints of your arms or legs such as pain, numbness, stiffness, joint noise, or arthritis of bursitis? □ Yes □ No E**xplain:** _____

RESPIRATORY:
Have you had any problems with shortness of breath, chest or rib pain when breathing, chronic cough, asthma, or bronchitis?
□ Yes □ No **Explain**:_____

SKIN:
Have you had problems with skin dryness, psoriasis, eczema, itching, rash, hives, excessive sweating or "sensitive" skin?
□ Yes □ No **Explain**:_____

NERVOUS:
Have you had pain, numbness, tingling, or other altered sensations of any part of your body, or have you ever suffered from chronic headaches, nervousness, dizziness or psychological disorder? □ Yes □ No
Explain:_____

GASTRO-INTESTINAL:
Have you had any disorders of the stomach or bowel such as pain, excessive gas, chronic diarrhea, nausea, vomiting, or reflux?
□ Yes □ No **Explain**:_____

GENITO-URINARY:
Have you ever had trouble with your kidneys or bladder such as chronic infection, pain, frequent urination, difficulty urinating, or discharge?
□ Yes □ No **Explain**:_____

CARDIOVASCULAR:
Have you had problems with blood pressure, chest pain, cholesterol problems, poor circulation, or heart rate or rhythm problems? □ Yes □ No **Explain**:_____

EARS/EYES/NOSE/THROAT:
Have you had problems with earache, sinus pain, sore throat, eye pain or visual disturbance, or discharge of the eyes, ears or nose?
□ Yes □ No **Explain**:_____

Do you suffer from any other conditions not mentioned above? □Yes □ No
Explain:_____

WOMEN ONLY: Have you had problems with your menstrual cycle, hot flashes, swollen, painful breasts, or discharge conditions?
□ Yes □ No
Explain:_____

Are you pregnant? □ Yes □ No If yes, pregnancy in weeks? _____ Number of children & their ages:_____/_____

Patient Signature: _____ Date: _____

HEALTH HISTORY CONTINUED:

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	never
Drink Alcohol:	□ occasional	□ often	never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	never
Cigarettes:	<1 pack/day	□ >1 pack	□ never
Wear Seat Belts:	□ occasional	□ always	never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	Parent □	Sibling
Hypertension	Parent □	Sibling
Stroke	Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

HISTORY OF CURRENT COMPLAINT:

Please identify the condition(s) that brought you to this office:

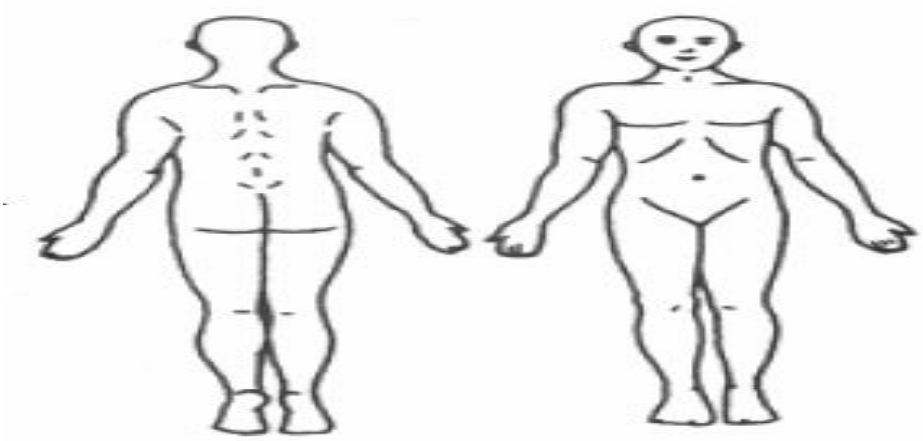
Primary: _____ Secondary: _____
Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your complaints by *circling the number*:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____
When is the problem at its worst? __AM __PM __NIGHT
How long does it last? __CONSTANT __ON AND OFF DURING THE DAY __COMES AND GOES THROUGHOUT WEEK
How did the injury happen?_____
Condition(s) ever been treated by anyone in the past: __NO __YES Date: _____ by whom:_____
How long were you under care: _____ What were the results:_____
_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms: _____

What makes your symptoms feel worse: _____

Patient Signature: _____ Date: _____

INFORMED CONSENT FOR EXAMINATION, TREATMENT, & PRIVACY PRACTICES

I hereby request and consent to examination and treatment on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Dr. Benjamin Ramey. Treatment includes chiropractic manipulation/adjustments and other chiropractic procedures, including various modes of physiotherapy, soft-tissue therapy, rehabilitative therapy and/or referral for diagnostic tests as necessary, I have had an opportunity to discuss with Dr. Ben Ramey the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, are in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

The Notice of Privacy Practices has been made available to me and I consent to the use or disclosure of my protected health information for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my care or to conduct health care operations of this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information and my rights and duties of this office with respect to my protected health information.

Patient Name_____ Patient Signature_____ Date_____

If Patient is a Minor:

Parent/Guardian Name_____ Relationship to Patient_____ Date_____

OFFICE FINANCIAL POLICY AND PAYMENT RESPONSIBILITY

No Insurance: In an effort to keep our fees as affordable as possible we offer a time of service discount. The time of service discount is as the name implies, a discount fee that must be paid at the time of service (or in advance). The time of service discount does not reflect our normal and customary fee; it is a discounted fee. In order to take advantage of the time of service discount, please plan ahead and have your payment ready. Any payments not made at the time that services are rendered will be at our usual fees.

Workers' Compensation: Workers' Compensation (WC) Claims- Patient must inform us prior to treatment that this is a WC Claim. Employer information and authorization is required prior to treatment. Our insurance specialist will submit WC Claims directly to the WC Insurance unless other arrangements have been made.

Personal Injury: If your claim is auto related and you have medical payment benefits available, we will bill all charges to YOUR motor vehicle insurance only. If you were a passenger in a motor vehicle, this would apply to the owner/driver's motor vehicle medical payment benefits availability. We DO NOT bill third party insurance.

Health Insurance: Health and accident insurance policies are a contractual arrangement between the insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for chiropractic health care benefits. Possession of medical insurance member ID card is NOT a guarantee of coverage. Therefore, we cannot accept responsibility for determining benefits in advance of your treatment or for collecting monies owed on your account from your insurance company. If you have insurance that will contribute to your care we will file your insurance for you through our billing company whenever possible. In order for us to bill your insurance, you and your insurance company must meet the following criteria:

- You are committed to your care plan
- You remain current with all deductibles and co-payments
- You understand that your insurance plan is an agreement between you and your carrier, not our office and your carrier. We will do everything in our power to facilitate payment from the insurance company on your behalf; however, you are ultimately responsible for your bill in the event that your insurance company does not pay for the services you have received. The responsible party is obligated for payment in full of the account. In the event your insurance company does not compensate us within 90days after billing, we must require you to pay to us directly and work out your difficulties with your insurance carrier. I, the undersigned, (or my dependent) certify that I have insurance coverage with _____ and assign directly to Wellspring Chiropractic Center LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions and direct payment to you of any sum I now or hereafter own you, by my attorney, out of proceeds of any settlement of my case, and/or by and insurance company obligated to make payment to me or you in whole or part upon the charges made for your services.

Patient Signature:_____Date:_____