Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Date: _____

Confidential Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State/Zip:_____ Email: _____

SS#: _____ Preference for Phone Call: *Home* *Cell*

Date of Birth: _____ Marital Status: M S W D # children: _____

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

****Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury?** (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Person to contact in case of emergency: _____ Phone: _____

How did you hear about our office? _____

Preference for appointment reminders: *email* *text*

We may communicate with you regarding personal healthcare information including but not limited to your care, insurance billing and balance information via email or voicemail. If you do not allow us to communicate with you in this way, please indicate below.

- □ Opt out of email messages
- □ Opt out of voicemail

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Sunbury Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. If I do not have insurance, I will pay at the time services are rendered.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Patient Name_____ **Date of Birth**_____

Please check any of the following symptoms which you now have or have had previously.

General		**Muscle & Joint**		**Respiratory**	
	Allergies		Arthritis		Chest pain
	Dizziness		Foot Trouble		Chronic cough
	Fainting		Low back pain		Difficult breathing
	Fatigue		Neck pain or stiffness		Spitting up blood
	Fever		Spinal curvature		Spitting up phlegm
	Headache				Wheezing
	Loss of Sleep	**Pain or Numbness**			
	Anxiety/depression		Shoulders	**Genito-Urinary**	
	Numbness		Arms		Bed Wetting
			Elbows		Blood in urine
Cardio-Vascular			Hands		Frequent urination
	Heart Disease		Hips		Inability to control Kidneys
	High Blood Pressure		Legs		Kidney infection or stones
	Low Blood Pressure		Knees		Painful urination
	Pain over heart		Feet		Prostate Trouble
	Poor Circulation		Tailbone		
			Sciatica	**For Women only**	
Eyes, Ears, Nose & Throat					Cramps or backache
	Asthma	**Gastro-Intestinal**			Hot flashes
	Colds		Constipation		Irregular cycle
	Earache		Diarrhea		Menopausal symptoms
	Ear Noises		Difficult Digestion		Painful Menstruation
	Eye Pain		Gallbladder Trouble		**Pregnant? *Yes* *No***
	Failing vision		Hemorrhoids		
	Nosebleeds		Nausea	**Mental Health**	
	Sore Throat		Pain over stomach		Anxiety
	Sinus Infection		Vomiting		Depression
			Poor appetite		Bipolar
					Other

Check the following conditions you have or had

	Alcoholism		Cold Sores		Influenza		Pleurisy		STD
	Appendicitis		Diabetes		Measles		Pneumonia		Stroke
	Arteriosclerosis		Eczema		Miscarriage		Polio		Tuberculosis
	Arthritis		Emphysema		Multiple Sclerosis		Rheumatic Fever		Ulcers
	Cancer		Epilepsy		Mumps		Scarlet Fever		Whooping Cough

Habits: Heavy/Moderate/Light/Never/Former

Alcohol_____Coffee_____Tobacco_____Drugs_____

Exercise_____

Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Patient Name_____ **Date of Birth**_____

What is your major complaint?_____

How long have you had this condition? _____

Have you had this or similar conditions in the past?_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? *Yes No Constant Comes and goes*

Is this condition interfering with your *Work Sleep Daily routine Other*_____

Other Complaints:_____

Have you had previous chiropractic care?_____ If yes, date of last treatment_____

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

Have you ever been knocked unconscious? _____ If yes, when?_____

Have you ever fractured a bone?_____

List all surgical operations and years: _____

_____

_____

List all medication, vitamins, or mineral supplements? (attach copy if necessary) _____

_____

_____

Do you have any medication allergies? _____ If yes, what?_____

_____

Do you wear any of the following: *Heel lifts Arch Supports Back Brace*

Have you ever had any mental or emotional disorders?_____If yes, When?_____

Family Health History: Many health problems are the result of hereditary spinal weaknesses; information about your family members give us a better picture of your total health.

Name	Relation	Past and Present Health Problems

For Office use only:

Height_____ **Weight**_____ **BP** _____**/**_____ **Pulse**_____

Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Policy and Authorization

At Sunbury Chiropractic Center, our motto is "Relief First, Wellness Always." Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans. Most of our patients have health or accident insurance that falls under one of the plans discussed in our financial Policy brochure. Regardless of our coverage, we will suggest the chiropractic care most appropriate for your condition.

I have received and read my copy of Sunbury Chiropractic's Financial Policy. I understand that my insurance benefits are an arrangement between myself and my insurance company, NOT between Sunbury Chiropractic Center and my insurance company.

Missed Appointments:

There is a fee charged for all **MASSAGE** appointments that are not canceled prior to a scheduled visit.

Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $25

Communications:

I give permission to Sunbury Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement. Also, in the event that we would need to communicate your healthcare information, including but not limited to diagnosis, treatment plan and insurance/financial coverage, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

Please complete the information below **IF** you allow us to release information to your Family Physician.

Physician Name/Practice Name:_____

Phone #: _____

I have read and fully understand the above statements.

Print Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Informed Consent

A patient gives the doctor permission and authority to care for them in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Sunbury Chiropractic Center**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

==========

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

==========

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

I under that some insurance plans consider spinal manipulation on children under the age of 2 years to be experimental and may not be covered. By signing this, you understand that your child's visit, if applicable, may be denied by the insurance company and you will be financially responsible for all denied services rendered.

==========

I understand that my doctor may submit my x-rays to Professional Imaging Consultants, Inc. for radiological evaluation and analysis by a Radiologist. There will **NOT** be a fee for this second opinion, as Sunbury Chiropractic Center will cover all costs as a courtesy.

Benjamin Glass, DC, DACBR
Chiropractic Radiologist
8230 Crystal Creek Dr.
North Royalton, OH 44133

==========

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy.

☐ I have been given a copy of the Policy
☐ I have declined a copy of the policy

Print Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____