

Please allow our staff to photocopy your driver's license and insurance card. All information you supply is confidential.

Whom may we thank for referring you to our office? _____

APPLICATION FOR CARE AT GEM CITY CHIROPRACTIC

Today's Date: _____

Patient's Demographics:

Name: _____ Birth Date: __/__/__ Age: ____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

Occupation: _____ Employer: _____

Would you like to receive appointment reminders via text messaging? Yes No

Email address: _____

Marital Status: M S D W Name of Spouse or Significant Other: _____

Number of children _____

Health Insurance: YES or NO

HISTORY of COMPLAINT

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

Chief complaint: _____

Secondary Complaint(s) or symptoms associated: _____

When did the problem(s) begin? _____ Is your problem the result of ANY type of accident YES or NO.

If Yes identify type: Auto Work Home Other (please explain) _____

Date of Accident: ____/____/____ approximately what time of day? ____ am ____ pm

Have you reported this accident to anyone? No / Yes If yes, when? _____

Other forms of treatment tried? _____, and who provided it _____

_____ When? _____

What were the results? Favorable Unfavorable... please explain: _____

PAST HISTORY

1: If you have ever experienced any of the following conditions at any time please mark with an X:

- | | | |
|--|---|--|
| <input type="checkbox"/> Moving Vehicle Accident | <input type="checkbox"/> Injury: Lifting, Falling etc | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Vascular Issues |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Jaw Pain / TMJ | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | |

SOCIAL HISTORY

- 1: Height _____ Weight _____ Blood Pressure _____ / _____
- 2: Smoking: Cigars _____ Pipe _____ Cigarettes..... How Often? Daily _____ Weekends _____ Occasionally _____ Never _____
- 3: Alcoholic Beverage: Consumption occurs... Daily _____ Weekends _____ Occasionally _____ Never _____
- 4: Recreational Drug use: Daily _____ Weekends _____ Occasionally _____ Never _____
- 5: List Prescription drugs you take:

6: Allergies to Prescription Drugs:

7: List Vitamins & Supplements / Non-Prescription drugs you take:

FAMILY HISTORY

1: Does anyone in your family suffer the same condition(s) you currently have? No /Yes (if yes whom)

Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2: Any other hereditary conditions the doctor should be aware of? No Yes: _____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GEM CITY CHIROPRACTIC FOR ALL BENEFITS WHICH MAY BE PAYABLE UNDER A HEALTHCARE PLAN OR FROM ANY OTHER COLLATERAL SOURCES. I AUTHORIZE UTILIZATION OF THIS APPLICATION OR COPIES FOR THE PURPOSE OF PROCESSING CLAIMS AND EFFECTING PAYMENTS. I ALSO FURTHER ACKNOWLEDGE THAT THIS ASSIGNMENT OF BENEFITS DOES NOT IN ANY WAY RELIEVE ME OF PAYMENT LIABILITY AND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE TO GEM CITY CHIROPRACTIC FOR ANY AND ALL SERVICES AT THE OFFICE.

Patient or Authorized Person's Signature

____/____/____
Date Completed

General Pain Index Questionnaire

We would like to know how much your pain *presently* prevents you from doing what you would normally do. Regarding each category, please indicate the *overall* impact your present pain has on your life, not just when the pain is at its worst.

Please *circle the number* which best describes how your *typical* level of pain affects these six categories of activities.

1. FAMILY/ AT HOME RESPONSIBILITIES SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

2. RECREATION INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

3. SOCIAL ACTIVITIES INCLUDING PARTIES, THEATER, CONCERTS, DINING-OUT AND ATTENDING OTHER SOCIAL FUNCTIONS-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

4. EMPLOYMENT INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

5. SELF-CARE SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

6. LIFE-SUPPORT ACTIVITIES SUCH AS EATING AND SLEEPING-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

Patient Name _____

Date _____

SCORE _____ (60)

BENCHMARK =5 _____

Patient Name: _____ Doctor: _____ Date: _____

IMPORTANT Please x all present symptoms

Rate pain by intensity levels using scale from 0-10 absent 0 1 2 3 4 5 6 7 8 9 10 excruciating pain

HEAD:

- Headache (R/L) rate pain (0-10)
- sinus (allergy) (0-10)
- entire head (0-10)
- back of head (0-10)
- forehead (0-10)
- temples (0-10)
- migraine (0-10)
- Head feels heavy
- Loss of memory
- Light headedness
- Fainting
- light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears (0-10)
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck (R/L) (0-10)
- Neck pain with movement
- forward (0-10)
- backward (0-10)
- low back pain (R/L) (0-10)
- bending right (0-10)
- bending left (0-10)
- turning right (0-10)
- turning left (0-10)
- Pinched nerve in neck
- Neck feels out of place
- Neck muscle spasms
- Neck grinding sounds
- Neck popping sounds
- Muscle spasms in shoulders
- Arthritis in neck

MIDBACK (blade area)

- Mid-back pain (R/L) (0-10)
- Pain in between blades (R/L) (0-10)
- Sharp stabbing
- Dull ache
- Pain in kidney area (0-10)
- Muscle spasms (R/L)

ARMS & HANDS:

- Pain in upper arm (R/L) (0-10)
- Pain in elbow (R/L) (0-10)
- Pain in forearm (R/L) (0-10)
- Pain in hands (R/L) (0-10)
- Pain in fingers (R/L) (0-10)
- Pins & needles sensation
- arms (R/L)
- hands/fingers (R/L)
- Numbness
- arms (R/L)
- hands/fingers (R/L)
- Pain aggravated by movement
- Tennis elbow (R/L)
- Hands feet cold
- loss of grip strength (R/L)
- Arthritis : shoulders (R/L) elbow (R/L) fingers (R/L)

SHOULDER JOINTS:

- Pain in shoulder joint (R/L) (0-10)
- Pain across shoulders (0-10)
- Bursitis (R/L)
- Arthritis (R/L)
- Can't raise arm
- above shoulder level
- over head
- Tension in shoulders
- Pinched nerve in shoulder (R/L)
- Muscle spasms in shoulders

CHEST:

- Chest pain (0-10)
- Shortness of breath
- Pain around ribs (0-10)
- Breast pain (0-10)
- Dimpled/orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids
- Foods can't eat _____

LOW BACK:

- Upper lumbar (R/L) (0-10)
- Lower lumbar (R/L) (0-10)
- Sacroiliac (R/L) (0-10)
- Low back pain is worse when:
- working (0-10)
- lifting (0-10)
- stooping (0-10)
- standing (0-10)
- sitting (0-10)
- bending (0-10)
- coughing (0-10)
- lying down (sleeping) (0-10)
- walking (0-10)
- low back feel better _____
- slipped disc
- pain from front to back
- low back feels out of place
- muscle spasms
- arthritis

HIPS, LEGS, & FEET:

- Pain in buttocks (R/L) (0-10)
- Pain in hip joints (R/L) (0-10)
- Pain down leg (R/L) (0-10)
- Knee pain (R/L)
- inside/medial (R/L) (0-10)
- outside/lateral (R/L) (0-10)
- leg cramps (R/L) (0-10)
- foot cramps (R/L) (0-10)
- Pins & Needles sensation in legs (R/L)
- Numbness
- legs (R/L)
- feet (R/L)
- toes (R/L)
- swelling
- legs (R/L)
- ankles (R/L)
- feet (R/L)
- feet feel cold (R/L)

WOMEN ONLY:

- Menstrual pain (where) _____ 0-10
- Cramping (severe/mod/mild)
- Irregularity
- Cycle _____ days
- Birth control _____ (type)
- Hysterectomy _____ (year)
- Complete
- Partial
- Hormone replacement therapy
- Genital cancer
- Discharge
- color
- Treatment _____
- Tumors
- Fibroids
- Menopause
- Premenstrual Syndrome
- Abortions

MEN ONLY:

- Frequent urination
- Difficulty in starting
- Difficulty in emptying completely
- Frequent night urination
- Prostate cancer (year diagnosed _____)
- treatment _____
- Enlarged prostate

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Feel run-down
- Arthritis
- Osteoarthritis
- where _____
- Rheumatoid
- Gout
- Fibromyalgia
- Diabetes
- insulin dependant
- non insulin dependant
- blood sugar
- control thru diet and exercise only
- Hypoglycemia
- normal hours of sleep _____
- lost hours of sleep _____
- weight gain _____ lbs. 1/3/6/12 months
- weight loss _____ lbs. 1/3/6/12 months
- soda _____ 12oz cans/day type _____
- cola/non-cola/diet/caffeine free
- coffee/tea _____ cups/day _____ decaf.
- cigarettes _____ packs/day
- vitamins (list) _____

REMARKS:

Patient Signature: _____

ASSIGNMENT OF BENEFITS

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Dr. Becky A. Grimm, D.C and/or Dr. Nicole Paxton, D.C.

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Not with standing denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

GEM CITY CHIROPRACTIC, LLC (GCC, LLC)

PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying GCC, LLC, in writing, except to the extent GCC, LLC has taken action and reliance on your consent. Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosure that GCC, LLC may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person. You have the right to request GCC, LLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. GCC, LLC is not required to agree to requested restrictions. If GCC, LLC agrees to the requested restriction, GCC, LLC will honor the request and it will e binding on the office. I hereby consent to the use and disclosure by Gem City Chiropractic, LLC, its workforce, and its business associated of my protected health information for the purpose of treatment, payment, and health care operations.

Signature _____ Date

Guardian Signature Relation to Patient Date

Gem City Chiropractic, LLC

FINANCIAL POLICY - GEM CITY CHIROPRACTIC, LLC

FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE - We request that 100% of the first visit and subsequent visits be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.

GROUP OR INDIVIDUAL INSURANCE - When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductible or co-pays.

"ON THE JOB" INJURY (Workers Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS - Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE - We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE - Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

INSURANCE ONE TIME AUTHORIZATION

I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Grimm or Dr. Paxton and my insurance company. I request that Gem City Chiropractic, LLC prepare the customary forms at no charge so that my insurance company can process my claim(s). I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Becky A. Grimm, D.C and/or Dr. Nicole G. Paxton, D.C., that fees will be due and payable immediately.

Gem City Chiropractic, LLC.

Signature

Date

Guardian Signature

Relationship to Patient

Date