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

Whom may we thank for your referral?_____

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 #: _____

Would you like to receive appointment reminders via text messaging? YES NO

Occupation:_____ Employer: _____

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

Number of children: _____

Health Insurance: YES or NO

OFFICE USE

Insurance Name: _____

ID #: _____ Group #: _____

Name as appears on card: _____

Past History:

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

(even if it seems as insignificant as falling off the monkey bars as a child)

___Moving Vehicle Accident	___Injury: Lifting/Falling, etc.	___Broken Bones
___Heart Attack	___Convulsions/Epilepsy	___Vascular Issues
___Disability	___Jaw Pain/TMJ	___Tremors
___Stroke	___Cancer	

Social History:

1: Height_____ Weight_____ Blood Pressure_____/_____

2: Smoking: Cigars Pipe Cigarettes (Circle one) 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 and Supplements or non-prescription drugs you take:

_____

_____

Family History:

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

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

Have they ever been treated for their condition? **Yes No I Don't Know**

2: Any other hereditary conditions the doctor should be aware of? **Yes/No** (if yes what)

_____

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 ND 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.

_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE COMPLETED**

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 the neck (R/L) (0-10)
__Neck pain with movement
- __forward (0-10)
- __backward (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
__Muscle spasms in neck
__Grinding sounds in neck
__Popping sounds in neck
__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 and 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 feel cold
__Swollen fingers
__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
- __above head

__Tension in shoulders
__Pinched nerve in shoulder (R/L)
__Muscle spasms in shoulders (R/L) _

CHEST:

__Chest pain (0-10)
__Shortness of breath
__Pain around ribs (0-10)
__Breast pain (0-10)
__Dimpled/ orange peel breast

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 dependent
- __Non-insulin dependent
- __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:

_____

_____

_____

NAME: _____

DATE: _____

ACTIVITIES DISCOMFORT SCALE

In the boxes below, mark the appropriate statements with an "X".

Activity	Doesn't Hurt At All	Hurts A Little (1, 2, 3)	Hurts Moderate (4, 5, 6)	Hurts Severly (7, 8, 9, 10)	Unbearable Pain Prevents Activity
1.Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing stairs					
9. Carrying					
10. Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household chores					
16. Gardening					
17. Sports					
18. Employment					

Financial Policy- Gem City Chiropractic L.L.C.

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 and subsequent visits be paid in full at the time of the visit unless other arrangements have been made 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-pay.

"ON THE JOB" INJURY/ WORK COMP- If you are inured on the job, you will need to inform your employer of the accident and obtain the name and address of the insurance carrier. 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 AUTO ACCIDENT- Please notify your auto insurance carrier of your visit to our office immediately. Notify your insurance dept. 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 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 ask 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 and my insurance company. I request that Gem City Chiropractic L.L.C. prepare the customary forms at no charge so that my insurance company can process my claims. 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. S.C. that fees will be due and payable immediately.

Gem City Chiropractic L.L.C.

Signature Date

Guardian Signature Relationship to Patient Date

ASSIGNMENT OF BENEFITS

I authorize that any insurance benefits or reimbursement for services rendered when 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. S.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 withstanding 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 L.L.C. (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 be 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 Relationship to Patient Date