Date_____

APPLICATION FOR CARE AT Ace Family Chiropractic

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

PATIENT DEMOGRAPHICS

Name: _____ **Birth Date:** _____-_____-_____ **Age:** _____ □ **Male** □ **Female**

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

E-mail Address: _____ **Phone Number:** _____

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Widowed** **Do you have Health Insurance:** □ **Yes** □ **No**

Employer: _____ **Occupation:** _____

Spouse's Name _____ **Spouse's Birth Date** _____-_____-_____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ **Relationship:** _____

HISTORY of COMPLAINT

Please identify the reason for your visit today. (ex: Headache, Low Back Pain, Mid Back Pain, Neck Pain, etc.)
On a scale of **1** to **10** with **10** being the **worst** pain and **0** being **no** pain:
Rate your areas of complaint by ***CIRCLING THE NUMBER:***

Primary Complaint:_____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second Complaint:_____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

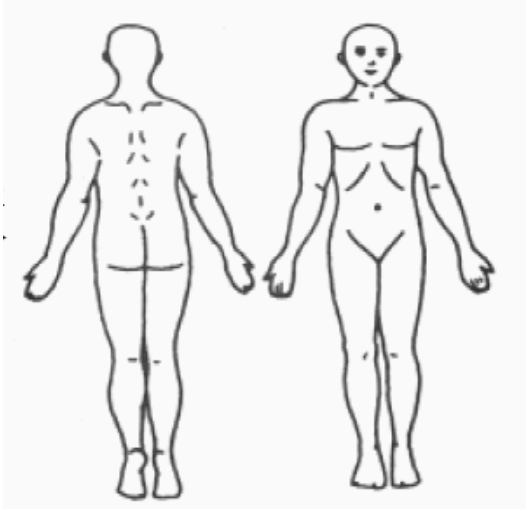
Third Complaint:_____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____
How did the injury happen?_____
When is the problem at its worst? □**AM** □ **PM** □**Mid-Day**
How long does it last? □ **Constant OR** □**Comes and goes daily OR** □**Comes and goes throughout the week**
Have you suffered with any of this or a similar problem in the past? □ **No** □ **Yes**
Condition(s) ever been treated by anyone in the past? □ **No** □ **Yes**
(If yes): When & By whom? _____
What were the results? _____ Previous Chiropractor?: □ **No** □ **Yes**
What **relieves** your symptoms? _____
What makes your symptoms **feel worse**? _____

Is your problem the result of ANY type of accident? □ **No** □ **Yes**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = **R**adiating
B = **B**urning
D = **D**ull
A= **A**ching
N = **N**umbness
S = **S**harp/**S**tabbing
T = **T**ingling



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please check:

□	Cancer/Tumors Type: _____	□	High Blood Pressure	□	Fractures _____	□	Stroke
□	Diabetes □ Type I □ Type II	□	Osteoarthritis	□	Rheumatoid Arthritis	□	Heart Problems

Other serious conditions: _____

Surgeries and/or Hospitalizations (List and Date)

_____

_____

SOCIAL HISTORY

1. Smoking: □ **cigars** □ **pipe** □ **cigarettes** **How often?** □ **Daily** □ **Weekends** □ **Occasionally** □ **Never**
2. Alcoholic Beverage: consumption occurs □ **Daily** □ **Weekends** □ **Occasionally** □ **Never**
3. Recreational Drug use: □ **Daily** □ **Weekends** □ **Occasionally** □ **Never**
4. Hobbies/Recreational Activities _____

List Current Prescription Medications & Nonprescription drugs you take:

_____

_____

FAMILY HISTORY:

Please list any pertinent conditions that run in your immediate family: _____

Ace Family Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Ace Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Patient or Authorized Person's Signature ***Date***

REGARDING: X-rays/Imaging Studies

FEMALES ONLY *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ **The first day of my last menstrual cycle was on** ____-____-____ **(Date)**

☐ **N/A**

☐ I have **been provided** a full explanation of when I am most likely to **become pregnant**, and to the **best of my knowledge**, I am **not** pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Patient or Authorized Person's Signature **Date**

ACE FAMILY
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FINANCIAL POLICY: Insurance Billing, Patient Responsibility and Payment Options

Insurance Billing:

We do our best to contact your insurance company and verify your insurance coverage prior to your visit, when possible. Please note, verification of benefits is NOT a guarantee of payment. You are responsible for any copays, deductibles, coinsurances or services not covered by your insurance plan.

We cannot promise that an insurance company will reimburse our office or you for the services rendered. In the event that an insurance company denies payment, it is your responsibility to pay these charges and seek reimbursement from your insurance company. It is your responsibility to let Ace Family Chiropractic know if your insurance policy has changed.

Patient Responsibility:

Payment for copays, deductibles and all other services are due **at the time of service.** If the insurance company does not pay within 45 days, the remaining balance may become your responsibility. You will receive a statement for any unpaid balances.

Payment for unpaid balances are due within 30 days of the statement date. Accounts remaining unpaid after 30 days will accrue a monthly late fee until the balance is paid in full. Accounts remaining unpaid after 90 days will be referred to a collections agency. If your account is sent to collections, you will be responsible for any additional fees.

We accept cash, debit/credit cards, checks, HSA/FSA cards and Care Credit. There is a $25 fee for returned checks.

Payment plans are available upon request and require a card on file. You may conveniently store a card on file with our office. This can be used for payment for services and outstanding balances. You will receive notice of any charges made to your card. Your information is stored securely and protected in compliance with HIPAA and PCI standards.

I have read and understand Ace Family Chiropractic's Financial Policy and agree to the terms above. If applicable, I authorize Ace Family Chiropractic to store and charge my card for any patient balances as described in this policy.

Signature: _____ Date: _____

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