DYNAMIC CHIROPRACTIC LLC

For office use:
Height:_____
Weight:_____
BPM:
_____
BP: _____

DEMOGRAPHICS

Patient name _____ SSN _____
Last First MI
I would prefer to be called _____ Date of Birth ___ /___ /___ Age_____ M ☐ F ☐
When was the last time you saw a Chiropractor? _____
Street Address _____
City_____ State_____ Zip Code _____
Cell Phone_____ Work Phone_____ Home Phone _____
Email _____
Occupation_____ How Long? _____
Employer/Address _____
Status: Minor Single Married Divorced Separated Widowed
Spouse's Name_____ Number of Children? _____
Who may we thank for your referral?_____ Primary Care Physician_____

HEALTH HISTORY

Are you currently taking any medications? ***Please list them below***

Medication Name	Dosage and Frequency

Do you have any medication allergies? ***YES/NO If yes please list below***

Medication Name	Reactions/Onset Date

Place a mark on "Yes" or "No" to indicate if you've had any of the follow:

AIDS/HIV	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No ☐
Allergies	Yes	No	Gout	Yes	No	Pacemaker	Yes	No ☐
Anemia	Yes	No	Heart Disease	Yes	No	Parkinson's Disease	Yes	No ☐
Arthritis	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No ☐
Asthma	Yes	No	Hernia	Yes	No	Prostate Issues	Yes	No ☐
Backaches	Yes	No	Herniated Disk	Yes	No	Rheum. Arthritis	Yes	No ☐
Cancer	Yes	No	Migraine Headache	Yes	No	Sinus Condition	Yes	No ☐
Concussion	Yes	No	Other Headaches	Yes	No	Stroke	Yes	No ☐
Diabetes	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Issues	Yes	No ☐
Digestive Disorders	Yes	No	Muscular Dystrophy	Yes	No	Tuberculosis	Yes	No ☐
Dizziness/Vertigo	Yes	No	Neuritis	Yes	No	Tumors	Yes	No ☐
Emphysema	Yes ☐	No ☐	Numbness	Yes	No	Ulcers	Yes	No ☐
Epilepsy	Yes ☐	No ☐	Other: _____					

Exercise
None ☐
Moderate ☐
Daily ☐
Heavy ☐

Work Activity
Sitting ☐
Standing ☐
Light Labor ☐
Heavy Labor ☐

Habits
Alcohol ☐
Caffeine ☐
High Stress ☐
Smoking ☐

Drinks/Week _____
Cups/Day_____
Reason_____
Pack/Day_____
Smoking Start Date:_____

Are you pregnant? Yes ☐ No ☐

Please describe any injuries or surgeries you have had: _____

FAMILY Hx : (for office use)

CONCERNS

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms: getting worse? ☐ getting better? ☐ staying the same? ☐

What treatment have you already received for your condition?

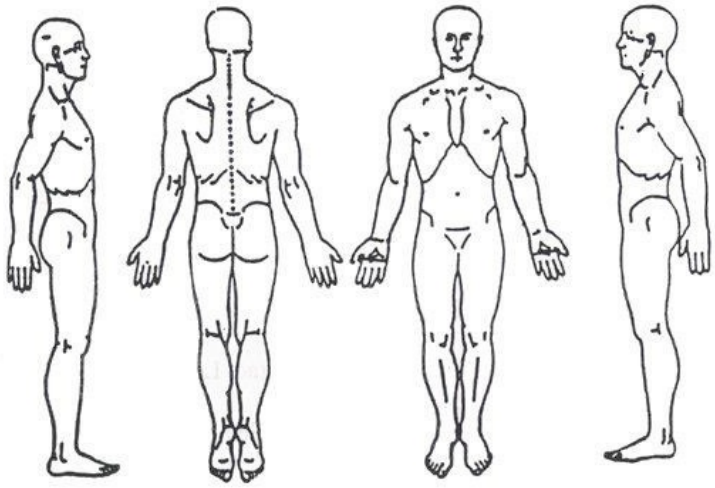
Medications ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other: _____

Rate the Severity of your pain on a scale from 1 (least pain) to 10 (most pain): _____/10

Type of pain:

Sharp ☐	**D**ull ☐	**Th**robbing ☐	**A**ching ☐	**Sh**ooting ☐
Burning ☐	**N**umbness ☐	**T**ingling ☐	**St**iffness ☐	**O**ther ☐

Place appropriate highlighted letters to mark the areas of discomfort



How often does this pain occur? Constant (+75%) ☐ Frequent (50-75%) ☐ Occasional (25-50%) ☐ Intermit (<25%) ☐

Does it interfere with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful: Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Other comments or concerns regarding this condition: _____

_____

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below that she is a licensed chiropractor, and though rare, injury resulting from manipulation may include sprain/strain, disc herniation, stroke, death and other injuries or complications.

I agree to hold Dr. Dillon Martinek; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatsoever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding on and insure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with the treating Doctor of Chiropractic, that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Patient Signature _____ Date _____

If patient is under 18:

Guardian Signature _____ Date _____

Financial and Insurance Disclaimer

Financial Policy

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, and/or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. In order to make this convenient, we accept most major credit cards, cash and personal checks. If, on occasion, it is not possible to pay in full, we are willing to establish a payment schedule with you. However, the balance may not exceed $250.00 and the full balance must be paid within 30 days. Personal balances over 30 days old may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility. A $20.00 fee will be applied to appointments not canceled within 12 hours of the scheduled appointment time. Appointments Monday must be canceled Friday before closing.

Insurance Policy

Our office works with insurance companies to accept your coverage. Our staff will call the insurance company to verify your coverage and will explain to you the information they obtain. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted us. NOTE: Verification is not a guarantee of benefits. We assume no responsibility for the information we receive from your insurance company, concerning how much or what your insurance company will pay for. The final financial responsibility is yours. Should you have questions at any time, do not hesitate to contact the staff or office manager.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dr. Dillon Martinek will submit services rendered for my care for payment under the contract I have with my health and/or accident carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered to me and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any unpaid fee for professional services rendered to me will be immediately due and payable.

Patient Signature_____ Date _____

If patient is under 18:

Guardian Signature_____ Date _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Patient Signature_____ Date _____

If patient is under 18:

Guardian Signature_____ Date _____

CMS requires providers to report both race and ethnicity:

Race (Circle One): American Indian or Alaska Native/ Asian / Black or African American
White(Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer **Preferred Language:** Eng Spanish Other