GREVE CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Personal Information

Full Name _____ Date _____

Mailing address _____
Street City State Zip

Home Phone ( )_____ Work Phone ( )_____

Cell Phone ( ) _____ Best time and place to contact you _____

Social Security # _____ Drivers License # _____

Marital Status: M S W D Age _____ Birth date _____ No. of children _____

Email Address: _____

Pregnant?_____ Height _____ Weight _____ Occupation _____

Spouse/Guardian Name _____

Employer's Name and Address _____

Name of person responsible for account _____

WHO MAY WE THANK FOR REFERRING YOU?_____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General History"** section

I. HEALTH CONCERNS

List health concerns according to their severity	Rate of severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit?

_____

What activities aggravate your condition? _____

Other Doctor's seen for this condition:
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) _____
Medical Dr. _____ Dentist _____ Other _____

1. Name/Address: _____
When: _____ What did they say was wrong? _____
What did they do? _____ Did it help? _____
2. Name/Address: _____
When: _____ What did they say was wrong? _____
What did they do? _____ Did it help? _____

Is this condition interfering with your: work____ sleep____ daily routine____ sports/exercise____
Other _____

GENERAL HEALTH HISTORY SECTION

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type_____ When_____ Hospitalized _____Yes _____No
2. Type_____ When_____ Hospitalized _____Yes _____No
3. Type_____ When_____ Hospitalized _____Yes _____No

Have you ever had x-rays taken? _____ When?_____ Where?_____
Area of body:_____
Do you wear orthotics or heel lifts? Yes_____ No_____

CURRENT MEDICINE(S)/SUPPLIMENTS:
Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)
_____
_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:
_____
_____

Diet:

Would you take whole food supplements if indicated?
YES _____ NO _____ MAYBE _____

PAST HEALTH HISTORY:
Mark the following conditions you may have had or have now (- have had +have now)

___ Allergy	___Diarrhea	___Measles	___Rheumatic Fever	___Alcoholism	___Eczema
___Miscarriage	___Stroke	___Anemia	___Multiple Sclerosis	___HIV (Aids)	___Gout
___Arteriosclerosis	___Emphysema	___Mumps	___Sinus Problems	___Arthritis	___Neuritis
___High Blood Pressure	___Asthma	___Nervousness	___Thyroid Problems	___Ulcers	___Cancer
___Heart Disease	___Depression	___Convulsions	___Venereal Disease	___Malaria	___Pleurisy
___Constipation	___Pneumonia	___Cold Sores	___Whooping Cough	___Polio	___Neck Pain
___Gall Bladder Problems	___Migraines	___Headaches	___Menstrual Cramps	___Back Pain	___Epilepsy
___Irregular Periods	___Diabetes	___Tuberculosis	___Heart Attack	___Low Blood Sugar	
___Ringing in ears	___Other (please explain)				

_____

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

How do you grade your emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

Is there anything else which may help to better understand you, which has not been discussed?
_____
_____
_____
_____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Robert L. Greve, D.C./Greve Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name_____ Date: _____

Signature _____

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 4 / 14 / 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Greve Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. *Please ask* if you have any questions about our fees, financial policy, or your responsibility.

Cash: It is our policy in this office to maintain your account on a current basis. ***Charges for treatment are due at the time the service is provided.*** Payment plans are available upon request.

Insurance: We will be happy to bill your insurance company for services rendered. HOWEVER, you understand that terms of your policy are BETWEEN YOU AND THE INSURANCE COMPANY. We do not have any control over policy benefits, and will not become involved in any disputes between you and your insurance company. Should your insurance company deny any charges incurred, you will be responsible for payment for those services in full. ***You are responsible for your deductible and co-payment.***

Medicare: You understand that Medicare only covers spinal manipulation for subluxations. Any and all other charges, including examinations, supports, supplements, and therapies are considered "non-covered services" and will not be paid for by Medicare. Payment for these non-covered services is due at the time of service. This office does accept Medicare assignment. All charges are subject to Medicare's annual deductible, and patient co-pay of 20% of covered charges.

If you find that you are unable to comply with your financial agreement, please contact our office to make other arrangements. Also, if you suspend or terminate your care with this office, your bill will be immediately due and payable. We reserve the right to charge a **late fee of $10 per month** on all account balances 30 days past due. You also agree to pay any costs incurred in the event that collection or litigation efforts are necessary.

_____ _____

Signature Date