Nordan Chiropractic Center®

Information/ Application For Care

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**

Name: _____ Today's Date: _____

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

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

Birth Date: _____ Age: _____ Marital Status: ❑ S ❑ M ❑ W ❑ D Num. of Children: _____

E-Mail Address: (Please put one letter or number per box and use Ø for zero.)

Your Employer: _____ Occupation: _____ Years on Job:_____

Employer's Address: _____ City: _____ Sate: _____ Zip: _____

Insurance Company: _____ Your SS#: _____-_____-_____

Do you have Medicare? ❑ Yes ❑ No Do you have Medicaid? ❑ Yes ❑ No

Name of Spouse/ Parent: _____ Birth Date: _____

Spouse/ Parent employed by: _____ Occupation: _____ Years on Job: _____

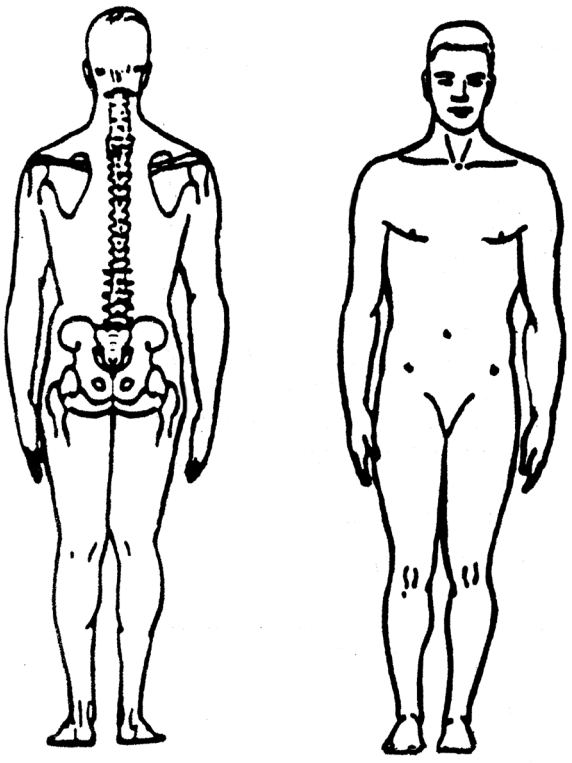
Spouse/ Parent Cell Phone: _____ Spouse/ Parent SS#: _____-_____-_____

Does your spouse have Health insurance at work? ❑ Yes ❑ No

Is your condition/ pain due to an accident? ❑ Yes ❑ No If yes Date of the Accident: _____

Type of accident: ❑ Auto ❑ Work/On Job ❑ At Home ❑ Other: _____

Have you ever been in an Auto Accident? ❑ Past Year ❑ Past 5 Years ❑ Over 5 Years ❑ Never



Directions

If you are in pain, please mark the exact location of your pain on the diagram. Also, describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, ect.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or experiencing.)

_____

_____

_____

_____

_____

_____

Referred to our office by: _____

BACK AND FRONT PLEASE FLIP OVER

Nordan Chiropractic Center

Agreements / Consent

CONSENT FOR TREATMENT / FINANCIAL STATEMENT

I, _____, consent to treatment necessary or desirable, including, but not restricted to, whatever physical therapy, examinations and conduct of laboratory, X-Ray, or other studies that may be used by the attending doctor, his nurse or qualified designate, I also acknowledge full responsibility for the payment of such services and agree to pay for them at the time of service. I understand that the patient or the responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment I agree to pay all costs of collection, including a reasonable attorney's fee.

I, (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance Cases: On all insurance assignments the deductible should be met in the beginning unless prior arrangements are made.

I have read the above statement(s) and I understand and agree to them.

Date:_____ **Signature:**_____
Patient, Parent, Agent

AUTHORIZATION TO RELEASE BENEFITS

I authorize Nordan Chiropractic Center to release any information to my case to any insurance company, adjustor, or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above mentioned office be given power of attorney to endorse (sign my name on) any and all checks for payment of my doctor bill. This also serves as authorization to release payment of benefits to Nordan Chiropractic Center.

I have read the above statement(s) and I understand and agree to them.

Date:_____ **Signature:**_____
Patient, Parent, Agent

Nordan Chiropractic Center®

Confidential Patient Case History

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
❑	❑	❑	Allergy
❑	❑	❑	Chills
❑	❑	❑	Convulsions
❑	❑	❑	Dizziness
❑	❑	❑	Fainting
❑	❑	❑	Fever
❑	❑	❑	Headache
❑	❑	❑	Loss of Sleep
❑	❑	❑	Loss of weight
❑	❑	❑	Nervousness/ depression
❑	❑	❑	Neuralgia
❑	❑	❑	Numbness
❑	❑	❑	Sweats
❑	❑	❑	Tremors
			MUSCLE & JOINT
❑	❑	❑	Arthritis
❑	❑	❑	Bursitis
❑	❑	❑	Foot trouble
❑	❑	❑	Low back pain
❑	❑	❑	Mid back pain
❑	❑	❑	Neck Pain or stiffness
❑	❑	❑	Pain between shoulders
			Pain or Numbness In:
❑	❑	❑	Shoulders
❑	❑	❑	Arms
❑	❑	❑	Elbows
❑	❑	❑	Hands
❑	❑	❑	Hips
❑	❑	❑	Legs
❑	❑	❑	Knees
❑	❑	❑	Feet
❑	❑	❑	Painful Tail bone
❑	❑	❑	Sciatica
❑	❑	❑	Spinal Curvature
❑	❑	❑	Swollen Joints

O	F	C	
			GASTRO-INTESTINAL
❑	❑	❑	Belching or gas
❑	❑	❑	Colitis
❑	❑	❑	Colon trouble
❑	❑	❑	Constipation
❑	❑	❑	Diarrhea
❑	❑	❑	Difficult digestion
❑	❑	❑	Distension of abdomen
❑	❑	❑	Excessive hunger
❑	❑	❑	Gall bladder trouble
❑	❑	❑	Hemorrhoids
❑	❑	❑	Intestinal worms
❑	❑	❑	Jaundice
❑	❑	❑	Liver trouble
❑	❑	❑	Nausea
❑	❑	❑	Pain over stomach
❑	❑	❑	Poor appetite
❑	❑	❑	Vomiting
❑	❑	❑	Vomiting blood
			EYES, EARS, NOSE, & THROAT
❑	❑	❑	Asthma
❑	❑	❑	Colds
❑	❑	❑	Crossed eyes
❑	❑	❑	Deafness
❑	❑	❑	Dental decay
❑	❑	❑	Earache
❑	❑	❑	Ear discharge
❑	❑	❑	Ear noises
❑	❑	❑	Enlarged glands
❑	❑	❑	Enlarged Thyroid
❑	❑	❑	Eye pain
❑	❑	❑	Failing vision
❑	❑	❑	Far sightedness
❑	❑	❑	Gum trouble
❑	❑	❑	Hay fever
❑	❑	❑	Hoarseness
❑	❑	❑	Nasal obstruction
❑	❑	❑	Nosebleeds
❑	❑	❑	Sinus infection
❑	❑	❑	Sore throat
❑	❑	❑	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
❑	❑	❑	Hardening of arteries
❑	❑	❑	High blood pressure
❑	❑	❑	Low blood pressure
❑	❑	❑	Pain over heart
❑	❑	❑	Poor circulation
❑	❑	❑	Rapid heart beat
❑	❑	❑	Slow heart beat
❑	❑	❑	Swelling of ankles
			RESPIRATORY
❑	❑	❑	Chest pain
❑	❑	❑	Chronic Cough
❑	❑	❑	Difficulty breathing
❑	❑	❑	Spitting up blood/ Phlegm
❑	❑	❑	Wheezing
			Skin
❑	❑	❑	Boils
❑	❑	❑	Bruise easily
❑	❑	❑	Dryness
❑	❑	❑	Hives or allergy
❑	❑	❑	Itching
❑	❑	❑	Skin eruptions (rash)
			GENITO-URINARY
❑	❑	❑	Bed wetting
❑	❑	❑	Blood in urine
❑	❑	❑	Frequent urination
❑	❑	❑	Inability to control kidneys
❑	❑	❑	Kidney infection/ stones
❑	❑	❑	Painful urination
❑	❑	❑	Prostate Trouble
❑	❑	❑	Pus in urine
			FOR WOMEN ONLY
❑	❑	❑	Congested breasts
❑	❑	❑	Cramps or backaches
❑	❑	❑	Excessive menstrual flow
❑	❑	❑	Hot flashes
❑	❑	❑	Irregular cycle
❑	❑	❑	Menopausal Symptoms
❑	❑	❑	Painful Menstruation
❑	❑	❑	Vaginal Discharge
❑Yes	❑No		Are you Pregnant?

CHECK THE FOLLOWING CONDITIONS: C- CURRENTLY HAVE H- HAVE HAD

C	H		C	H		C	H		C	H		C	H	
❑	❑	Aids	❑	❑	Diphtheria	❑	❑	Malaria	❑	❑	Polio	❑	❑	Venereal disease
❑	❑	Anemia	❑	❑	Eczema	❑	❑	Measles	❑	❑	Rheumatic fever	❑	❑	Whooping cough
❑	❑	Alcoholism	❑	❑	Emphysema	❑	❑	Miscarriage	❑	❑	Scarlet fever			
❑	❑	Appendicitis	❑	❑	Epilepsy	❑	❑	Multiple sclerosis	❑	❑	Stroke			
❑	❑	Arteriosclerosis	❑	❑	Goiter	❑	❑	Mumps	❑	❑	Tuberculosis			
❑	❑	Arthritis	❑	❑	Gout	❑	❑	Pleurisy	❑	❑	Typhoid fever			
❑	❑	Cancer	❑	❑	Heart disease	❑	❑	Pneumonia	❑	❑	Ulcers			
❑	❑	Chorea	❑	❑	HIV									
❑	❑	Diabetes	❑	❑	Influenza									

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Nordan Chiropractic Center®

Confidential Patient Case History

PLEASE PRINT

What's your major complaint? _____

_____

List surgical operation and years: _____

_____

Drugs you are now taking: ❑ Nerve pill ❑ Pain Killers ❑ Muscle relaxers ❑ "Pep" pills ❑ Tranquilizers ❑ Birth control pill

Other:_____

Age of mattress:_____ ❑ Comfortable ❑ Uncomfortable Do you use a bed board ❑ Y ❑ N

Describe: _____

Are you wearing: ❑ Heal lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

Have you ever had a mental or emotional disorder(s)? ❑ Yes ❑ No If yes When?_____

Have other in your family had such disorders(s)?❑ Yes ❑ No If yes When?_____

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE BRIEFLY**
Been knocked unconscious?	❑	❑	_____
Used a cane, crutch, or other support?	❑	❑	_____
Been treated for a spine or nerve disorder?	❑	❑	_____
Had a fractured bone?	❑	❑	_____
Been hospitalized for anything other than surgery?	❑	❑	_____
DO YOU:			
Now take vitamins or minerals?	❑	❑	_____
Think you may need vitamins or minerals?	❑	❑	_____
Have an allergy to any drug?	❑	❑	_____

DATE OF LAST:	**Less than 6 months**	**6-18 months**	**Over 18 months**	**Never**
Spinal examination	❑	❑	❑	❑
Physical examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest X-ray	❑	❑	❑	❑
Spinal X-ray	❑	❑	❑	❑
Dental X-ray	❑	❑	❑	❑
Urine test	❑	❑	❑	❑

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name:_____

Address:_____ **Phone**: _____

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140 (800) 442-1202

PATIENT _____ **CLINIC** _____ **FILM DATE** _____

AGE____ **SEX M** □ **F** □ **SOCIAL SECURITY#**_____/_____/_____ **DATE OF BIRTH** _____

PATIENT ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of American Radiological Services are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE:_____ **DATE:**_____

WITNESS:_____

PATIENT HISTORY

PATIENT PRESENTATION_____
_____

TRAUMA? YES □ **NO** □ **EXPLAIN**_____

PAST MEDICAL HISTORY_____
_____

MALIGNANCY? YES □ **NO** □ **DETAILS**_____

DIAGNOSIS/CONCERNS/QUESTIONS[NO ICD CODES PLEASE]_____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE