DR. SHORT NEW PATIENT FORMS

Name _____
Date_____
EMAIL _____
Phone (text for reminders) _____

Address _____
(city,state, zip)
How did you hear about us? _____
SSN _____ DOB_____ age _____
Occupation/Employer_____
Marital Status (circle) S W M D child
Spouses name _____
Spouses occupation/employer _____
Emergency contact _____
(name, relationship, contact info)

DO you agree to (cirlce all that apply) communication via:
TEXT PHONE CALL EMAIL

(WE WILL NEED A COPY OF YOUR DRIVER'S LICENSE)

Auto Accident Insurance: Name of company _____
Claim # _____

Name of the insured _____ I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ DATE_____

Medical history:
Please describe any conditions you have been treated for currently or in recent years.

_____
_____

Is there any chance you are pregnant? Y N
What medications/supplements are you currently taking?

_____
_____
_____

Have you ever been hospitalized (explain)?

_____
In an auto accident/when?

_____
Been struck unconscious/when?

_____
Had surgery/what/when?

_____
Do you smoke? Y N
Are you allergic to any medications? _____

Family history
Any serious health issues? (circle) STROKE, CANCER, DIABETES, HEART ATTACK
Who?_____
Other:_____

PATIENT-
Nature of injury (circle) auto accident work other
Please describe: _____
_____
_____
Date of injury _____
Have you had this condition before? Y N
Have you ever seen a chiropractor before? If so, when and where?
_____

Describe YOUR pain: (circle) dull achy sharp stabbing throb numb shooting
Where is your pain? _____
When did the pain start? _____
Does it wake you up at night? Y N
Does weather affect your pain? Y N
What makes your pain worse? _____
What makes it better? _____

Is the pain worse upon waking and improves during the day? Y N
Do you have numbness? Y N does it go into (circle) toes fingers
Does the pain/numbness cross your knee joint? Y N
Does it hurt when you cough/sneeze? Y N
Is the pain constant and daily? Y N _____
Scale from 1-10 (10 being worst) how bad is the pain? _____

FINANCIAL POLICY

Insurance

Dr. Short does NOT accept insurance. We will supply you with an invoice that you can submit to your insurance.

Payment

Patients are expected to pay for services in FULL at the time of visit. We accept cash, checks and most major credit/debit cards.

Fees

If you are not able to keep an appointment, we would appreciate advanced notice. There is a charge of $28 for all missed appointments and all NEW patients that give less than a 4 hour notice.

If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $28 re bill fee for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to IC systems collection agency for payment directly to them. You agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 18% of the account balance, and all costs and expenses including reasonable attorney fees we incur in such collection efforts.

A $28 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Responsible party _____Date _____