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)

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?

____

Insurance: (we will need a copy of your driver's license and insurance card)

Member ID __________________________ Group # __________

Name of company ____________________

Claim # if auto accident ________________

Name of the insured ___________________________________I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Although Dr. Short may file my insurance as a courtesy to me, 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 ____

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:

____

____

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

According to your insurance plan, you are responsible for any and all co payments, deductibles and coinsurances. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

It is a courtesy for our office to file your insurance. If it is denied for any reason, you are responsible for payment in full. It is your responsibility to understand your benefits with regard to covered and non covered services. It is your responsibility to know if written referral or authorization is required for services.

Payment

Self pay patients are expected to pay for services in FULL at the time of visit. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance.

Patient balances are billed immediately on receipt of your insurance plans explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. We accept cash, checks and most major credit/debit cards.

Fees

If you are not able to keep an appointment, we would appreciate 24 hour notice. There is a charge of $25 for all missed appointments and all NEW patients that give less than a 24 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 $25 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 $25 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 __________________