

New Patient Registration Form for F.H.

Today's Date /

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Preferred to be called _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / Age _____ Gender (check one) Male Female Unspecified

SS# _____ Marital Status (check one) Single Married Other

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Continued ...

Name _____

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
 What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
 What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen Question: (minimum of 6 letters) _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
No interest *Very Interested*

Current medications, including dosage if known.

If there are no current medications, check here:

- 1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

For Women: Are you taking Birth Control? Y N Are you Pregnant? Y N How Long? _____ Nursing? _____

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
2) _____ 4) _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension/High Blood Pressure presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

Health History:

List any fractures you have ever had: _____

List any previous surgeries : _____

List any past serious accidents with dates: _____

Family Health History: _____

Medical Doctor: _____ Phone # _____

To be performed by clinic staff: Height: _____ inches Weight: _____ pounds

BP: _____ Pulse: _____

Name _____

The reason for this visit? (work, sports, auto, trauma, chronic) **Explain what happened:** _____

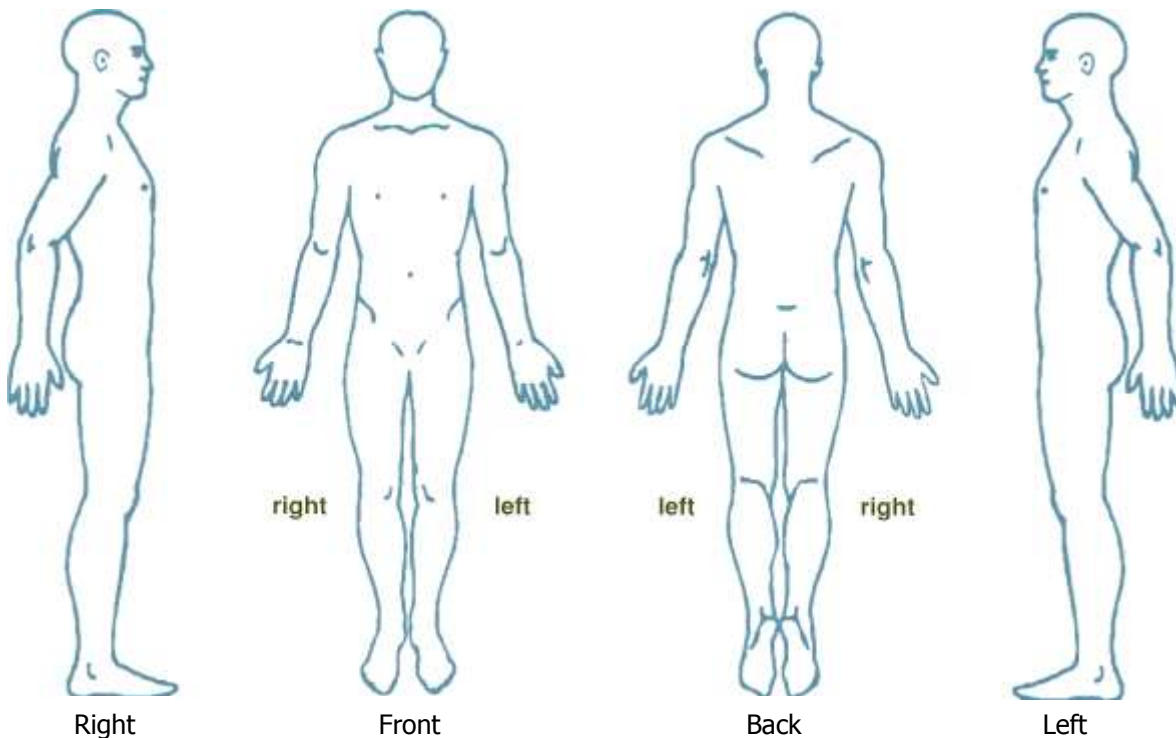
When did condition begin? ____/____/____ Is it interfering with? work, sleep, or daily routine If so, explain: _____

Have you been treated by a Medical Doctor/Chiropractor for this? Y N If so, where/whom? _____

Please mark area(s) of injury or discomfort. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme).

Description→	Dull	Sharp	Throbbing	Burning	Aching	Tingling	Cramping	Stabbing	Numbness
Symbol→	DDD	PPP	TTT	BBB	AAA	GGG	CCC	SSS	NNN

○ Circle any area of pain not represented by a symbol.



Severity of Pain:

Mild-----Mild to Moderate-----Moderate-----Moderate to Severe-----Severe
1 2 3 4 5 6 7 8 9 10

Frequency of Pain:

Occasional-----Comes and Goes-----Frequent-----Constant

Aggravating Factors

- | | | | | | |
|---|---------------------------------------|---|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Straining | <input type="checkbox"/> Reaching | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Looking up | <input type="checkbox"/> Looking down | <input type="checkbox"/> Movement | <input type="checkbox"/> Rest | <input type="checkbox"/> Lying Supine | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Typing | <input type="checkbox"/> Scooping | <input type="checkbox"/> Household chores | | <input type="checkbox"/> Exercise | <input type="checkbox"/> Stair Stepping |
| <input type="checkbox"/> Other Activities _____ | | | | | |

Relieving Factors

- | | | | |
|--------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Knees Bent up | <input type="checkbox"/> Support |
| <input type="checkbox"/> No Movement | <input type="checkbox"/> Movement | <input type="checkbox"/> Heat <input type="checkbox"/> Ice | <input type="checkbox"/> Analgesic Topical |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Medication | <input type="checkbox"/> Rest | <input type="checkbox"/> Stretching/Exercise <input type="checkbox"/> Adjustments |

Billing Information

Name _____

Patient Employer: _____ Occupation/Duties: _____

Spouse's Name: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone# _____

(Other than spouse)

Responsible Party / Insurance Information:

Name: _____ Relation: _____

Billing Address: _____

City

State

Zip

Phone# _____ DOB: ____/____/____ SS# _____ - _____ - _____

Employer: _____ **Payment Method:** CASH CHECK C.C. (MC / Visa)

Company Name: _____ Phone # _____

Address: _____ Insured's ID # _____

Group # (plan, local, or policy #) _____

Please inform the front desk if you have a 2nd Insurance.

(initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider Geise

Chiropractic, LLC. for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I have agreed to pay in a current manner any balance of said professional service charges over and above.

(initial) I authorize release of information, report of my diagnosis, treatment, prognosis and recommendations, to all my **INSURANCE COMPANIES AND ATTORNEY'S** (if applicable), I also understand if the insurance company deems a service to be non-covered I am responsible for payment of those services (i.e. braces, exercise bands, Orthotics, vitamins, and nutritional supplements, etc.)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

***Signature:** _____ **Date:** ____/____/____

Adult Patient Parent or Guardian Spouse

WELCOME

On behalf of the GEISE CHIROPRACTIC staff, we would like to welcome you to our office.

- ❖ It is critical that you follow the appointment schedule for your particular case. If for some reason you are unable to keep an appointment, we would greatly appreciate it if you would contact this office to reschedule your appointment to allow another patient to utilize that time period. To achieve the results, which we are, both working for, it is very important that you maintain the appointment schedule and follow the instructions you are given.

Methods of payment: Below is a list of the options our office offers you for payment of your care.

1. **CASH:**

You may pay for each treatment as it is received. Our establishment fee schedule is available for your review at the front desk. You will automatically receive an itemized statement at the end of each month. If you are not insured and are unable to pay in full each visit, please see the office assistant.

Any balance past 90 days will be charged 1.5% interest per month.

2. **MAJOR MEDICAL INSURANCE ASSIGNMENT**

If your policy is qualified and proved to cover chiropractic services, it is the policy of this office to bill insurance companies for the patient and payments will be mailed to this office. Any remaining balance will be the patient's responsibility. This enables you to have fewer out-of-pocket expenses. We do, however, request that you pay the percentage that the insurance company does not cover at each visit plus the deductible.

3. **MEDICARE**

Refer to your Advance Beneficiary Notice.

4. **MEDICAID**

Age 20 and under have 30 visits per 12 month period. Over age 21 has 15 visits per 12 month period.

5. **VISA/MASTERCARD/DISCOVER**

You may use either one of these cards to pay for your visits.

6. **If you do not have insurance or if our office is not on your insurance network, we can offer a Time of Service (TOS) discount.**

In order to receive the TOS, payment must be made the same day as the services. You cannot pay for services at a later date (example—paying for the services the next day or the end of the week) and still receive the TOS discount. Medicare, Medicaid and Worker's Compensation patients will not be able to take advantage of the TOS discount, because we are required to bill them directly. If you have any questions please feel free to ask the staff or Dr. Geise.

*** I authorize release of information, report of my diagnosis, treatment, prognosis and recommendations, to all my INSURANCE COMPANIES, WORKER'S COMPENSATION AND ATTORNEY'S (if applicable), I also understand if the insurance company or workers compensation deem a service to be non-covered I am responsible for payment of those services (i.e. braces, exercise bands, Orthotics, vitamins, and nutritional supplements, ect.)

Please Initial _____

I authorize Payment for any professional or Chiropractic benefit allowable to be made out and mailed directly to Geise Chiropractic, LLC (David M. Geise D.C.). This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

****If you have a CO-PAY or a Deductible to meet, payment is expected at the Time of Service.**

So that we are aware that you have read our office policy, please sign below.

*Signature _____ Date _____

Office Witness _____ Date _____