CONFIDENTIAL PATIENT HEALTH HISTORY RECORDS Date: ____/____/_____

Name:(First)_____(M)____(Last)_____ Nick Name: _____

Address: _____City:_____ST:____Zip: _____

Home (_____)_____ **Cell** (_____)_____ **Sex:** ☐M ☐F ☐ OTHER _____

(*Please note*: If no phone, provide an alternative emergency phone number) **Marital Status:** ☐ M ☐ S ☐ D ☐ W

DOB: _____/_____/_____ **AGE**:_____ **SS#**_____-_____-_____ **(Confidential information is not shared)**

Military: ☐Yes ☐No (*Years in Service*: ___) **Appointment Reminder** ☐ Email _____ ☐ Opt Out

Occupation:_____Employer:_____Yrs/Mths_____Phone:_____

Spouse:_____Phone:(_____)_____Employer:_____

Emergency Contact: ☐Spouse☐Parent☐Other Name:_____Phone:(_____)_____

Primary Care Doctor: _____Clinic:_____

Phone (_____)_____Date Last Seen: _____/_____/_____ For: _____

Education Level: ☐ Some High school (____*Years*) ☐ High School Graduate (_____*Year*)
☐ Tech School (____*Years*_____*DGR*) ☐College (____*Years*_____*DGR*)

If A Minor Parents Name: Mother: _____ Father: _____ Guardian: _____

Insurance/None Bill Information.

I wish to pay for services out of pocket and not have an insurance billed. ☐ Yes (Cash, Check, Credit Card)

Primary Insurance Provider:_____Health Savings: ☐Yes ☐No

Main Policy Carrier: ☐Self ☐Spouse ☐Parent ☐Other (Name_____ DOB_____)

Supplemental/Union Provider:_____

Main Policy Carrier: ☐Self ☐Spouse ☐Parent ☐Other (Name_____ DOB_____)

Initial Complaint (Please fill to the best of your knowledge)

What is your primary medical issue or concern?

_____

_____

When did your symptoms appear? _____

Work related? ☐ Yes ☐ No Date of Injury: _____ Auto Accident ☐ Yes ☐ No Date of Injury: _____

Can you explain what you feel may have caused your symptoms?

_____

_____

Are your symptoms: ☐ Getting worse? ☐ Getting better? ☐ Same ☐ Comes and Goes

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Massage Therapy

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) and dates that treated you for this condition:_____

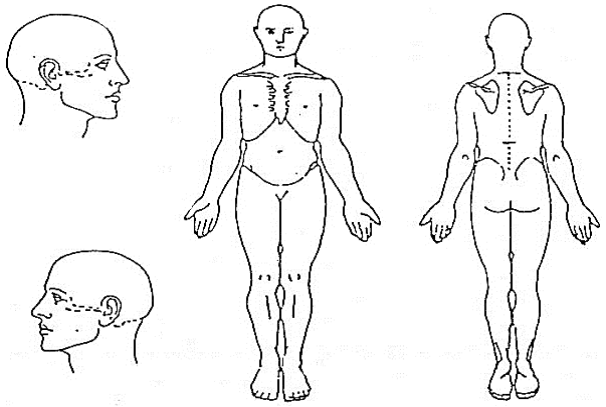
_____

_____

CONFIDENTIAL PATIENT HEALTH RECORDS

Place the appropriate symbols to mark the areas of discomfort you are experiencing.

XXX BURNING (BU)
(((ACHING PAIN (AC)
OOO PINS & NEEDLES (PI)
: : : NUMBNESS (NU)
/ / / SHARP PAINS (SH)



For Office Use Only
☐ Constant
☐ Come/Go ☐ Better
☐ Worse ☐ Same

Better: Worse:
_____ AM _____
_____ MIDDAY _____
_____ PM _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) 0 1 2 3 4 5 6 7 8 9 10

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that is painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Getting Out of Chair ☐ Other _____

Other comments or concerns regarding your condition:

_____

_____

Review of symptoms (Check Symptoms and The Corresponding Side of Symptom)

General

☐ Chills ☐ Fainting ☐ Loss of Weight ☐ Convulsions ☐ Fever
☐ Ringing in Ears ☐ Dizziness ☐ Headaches ☐ Sweats ☐ Depression
☐ Light Headaches ☐ Tremors ☐ Fatigue ☐ Loss of Sleep ☐ Other_____

How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

_____

_____

Neck

☐ Pain in Neck (L or R) ☐ Neck Stiffness ☐ Muscle Spasms in Neck ☐ Popping/Grinding Sounds in Neck

How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

_____

_____

Mid Back:

☐ Pain Between Shoulder Blades ☐ Mid Back Muscle Spasms ☐ Pain Around Ribs
☐ Pain on Deep Breathing ☐ Other _____ ☐ Other _____

How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

_____

_____

Low Back:

☐ Low Back Pain (L / R) ☐ Pain in Buttock (L / R) ☐ Pain In Hip (L / R)
☐ Pain Down Leg (L / R) ☐ Numbness of Leg (L / R) ☐ Numbness of Feet (L / R)
☐ Numbness of Toes (L / R) ☐ Leg Cramp (L / R) ☐ Knee Pain (L / R)
☐ Ankle Pain (L / R) ☐ Pins and Needles in Leg (L / R) ☐ Swollen Ankle (L / R)
☐ Foot Pain (L / R) ☐ Groin Pain ☐ Other _____

Worse When: ☐ Lifting ☐ Stooping ☐ Sitting ☐ Standing ☐ Coughing ☐ Bending

How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

_____

_____

_____

_____

CONFIDENTIAL PATIENT HEALTH RECORDS

Shoulders/Arms/Hands:

☐ Pain in Shoulder Joint	(L / R)	☐ Can't Raise Arms Above Shoulder level	(L / R)
☐ Tension in Shoulder	(L / R)	☐ Pain in Upper Arm	(L / R)
☐ Numbness in Upper Arm	(L / R)	☐ Pain in Forearm	(L / R)
☐ Numbness in Fore Arm	(L / R)	☐ Sensation of Pins and Needles in Forearm	(L / R)
☐ Pain in Hands or Fingers	(L / R)	☐ Fingers Go to Sleep	(L / R)
☐ Swollen Hands or Fingers	(L / R)	☐ Loss of Grip Strength	(L / R)
☐ Elbow Pain	(L / R)	☐ Wrist Pain	(L / R)
☐ Hand Pain	(L / R)	☐ Hand Numbness	(L / R)
☐ Sensation of Pins and Needles in Hands	(L / R)	☐ Other _____	

How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

_____

_____

Cardiovascular:

☐ Hardening of the Arteries	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Pain Over Heart
☐ Poor Circulation	☐ Slow Heart Beat	☐ Swelling of Ankles	☐ Arrhythmia

_____

_____

Eyes/Ears/Nose/Throat:

☐ Asthma	☐ Sore Throat	☐ Deafness	☐ Earache/Noises	☐ Ear Discharge
☐ Sinus Infection	☐ Enlarged Glands	☐ Enlarged Thyroid	☐ Nose Bleeds	☐ Failing Vision
☐ Gum Trouble	☐ Hay Fever	☐ Hoarseness	☐ Belching or Gas	☐ Nasal Obstruction

_____

_____

Respiratory:

☐ Chest Pain	☐ Chronic Cough	☐ Difficult to Breath	☐ Shortness Of Breath	☐ Spitting Blood
☐ Spitting up Phlegm	☐ Wheezing	☐ Other _____		

_____

_____

GENITO/URINARY:

☐ Bedwetting	☐ Blood in Urine	☐ Frequent Urination	☐ Inability to Control Bladder
☐ Painful Urination	☐ Prostate Trouble	☐ Kidney Infections or Stones	☐ Painful Menstruation
☐ Hot Flashes	☐ Irregular Cycle	☐ Lumps in Breast	☐ Erectile Disfunction
☐ Other_____			

_____

_____

GASTROINTESTINAL:

☐ Colitis	☐ Colon Trouble	☐ Constipation	☐ Diarrhea	☐ Difficult Digestion
☐ Jaundice	☐ Hemorrhoids	☐ Intestinal Worms	☐ Nausea	☐ Gall Bladder Trouble
☐ Vomiting	☐ Excessive Hunger	☐ Liver Trouble	☐ Pain Over Stomach	☐ Distention of Abdomen
☐ Bloating	☐ Excessive Bowel Gas	☐ Excessive Thirst	☐ Other_____	

_____

_____

Please provide any additional information you want the doctor to know:

_____

_____

_____

CONFIDENTIAL PATIENT HEALTH RECORDS

Pediatrics (For children 12 and under)

Child birth was: ☐ Vaginal Birth ☐ C-Section **Was the child**: ☐ Early (How early:_____) ☐ Late (How late:_____)

Please check any that apply: ☐ Breech ☐ Induction ☐ Vacuum Extraction ☐ Forceps ☐ Other_____

Childs birth weight: _____LBS. _____OZ Height:_____IN **Is/Was** ☐ Breastfed ☐ Formula ☐ Cow/Goat Milk

Does child ever suffer from: ☐ Colic ☐ Reflux ☐ Ear Infection ☐ Constipation ☐ Allergies ☐ Difficulty Feeding

☐ Fevers ☐ Trouble Sleeping ☐ Trouble Crawling ☐ Excessive Crying ☐ Rashes ☐ Slow Learning ☐ Hearing

Anything else you want the doctor to know:_____

History

Date of most resent:

Physical Exam X-Ray:____/_____/_____ Spinal Exam:____/_____/_____ MRI, CT or Bone Scan:____/_____/_____

Past surgeries: _____

_____

Past Accidents or Injuries: _____

_____

List medications? _____

_____

Have you seen a chiropractor before? ☐ Yes ☐ No Dr. Name:

_____

Reason: _____

Not yourself, Immediate/Extended Family Health:	Father	Mother	Grandparent	Other
☐ Heart Related (*Type*_____)	☐	☐	☐	☐ _____
☐ Cancer (*Type*_____)	☐	☐	☐	☐ _____
☐ Thyroid (*Type*_____)	☐	☐	☐	☐ _____
☐ Stroke (*Type*_____)	☐	☐	☐	☐ _____
☐ Kidney (*Type*_____)	☐	☐	☐	☐ _____
☐ Immune Disorder (*Type*_____)	☐	☐	☐	☐ _____
☐ Blood Pressure (*Type*_____)	☐	☐	☐	☐ _____
☐ Diabetes (*Type*_____)	☐	☐	☐	☐ _____
☐ Depression (*Type*_____)	☐	☐	☐	☐ _____
☐ Other (*Type*_____)	☐	☐	☐	☐ _____

Personal Habits

EXERCISE	**WORK**	**SOCIAL HABITS**
☐ None	☐ Sitting	☐ Smoking (Packs/Day _____)
☐ Moderate	☐ Standing	☐ Alcohol (Drinks/Week _____)
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks (Cups/Day _____)
☐ Heavy	☐ Heavy Labor	☐ High Stress (Reason _____)

Are you potentially or currently pregnant? ☐ Yes ☐No Due Date _____/_____# Of Children:_____

PLEASE FILL SECTION 1 OR 2 IF APPLICABLE. OTHERWISE SKIP TO SIGNATURE:

1. MEDICAL REPRESENTATIVE INFORMATION

Please fill out if person is unable to make medical choices for themselves and needs a legal reprehensive on file.

I have _____ representative that handles my Medical and Financial accounts. Phone: H_____ C_____

2. AUTHORIZATION TO TREAT A MINOR

Please fill out for children 17 and under and only parent or guardian sign.

I _____ HEREBY AUTHORIZE DR STEVEN J FELICIJAN TO ADMINISTER CHIROPRACTIC CARE AS HE DEEMS NECESSARY TO MY SON/DAUGHTER _____.

DATED AT PARDEEVILLE, WI ON THIS _____DAY OF _____, 20_____.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL THE ABOVE STATEMENT'S ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORIZATION FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT SO APPROVED.

X _____ X _____

PRINT FULL NAME TODAYS DATE

X _____

Patient/Guardian Signature

OFFICE PERSONAL

DATE:____/____/_____

VERIFIED STAFF SIGNATURE:_____

Financial Policy

Please read carefully and Felicijan Chiropractic Office will help you with any questions you may have. Felicijan Chiropractic Office strives to provide the highest quality health care, all the while maintaining affordability for you, the patient. Felicijan Chiropractic Office understands that even with insurance, most patients will experience at least some out-of-pocket expense. Please provide any primary, secondary insurance or union participation card at time of visit. Patient is responsible for giving any updated information regarding insurance changes.

Participating Insurances

Felicijan Chiropractic Office will accept your insurance on assignment and participate as preferred providers for many insurance plans. As a **courtesy** Felicijan Chiropractic Office will file your claims for you and assist you in every way possible to ensure benefit recovery. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. **Felicijan Chiropractic Office will not enter into a dispute with your insurance company over policy limitations or issues**. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Felicijan Chiropractic Office cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. Felicijan Chiropractic Office will contact your insurance provider to verify your policy benefits; however, the benefits quoted to Felicijan Chiropractic Office by your insurance company are not a guarantee of payment. It is Felicijan Chiropractic Office policy that any services rendered are charged to you directly and you are responsible for payment in full at the time-of-service for any non-covered services, deductibles or co-pays.

Non Participating Insurances

Felicijan Chiropractic Office is **not a participating provider** with your current insurance company; therefore, payment may be requested at time of service. As a **courtesy** Felicijan Chiropractic Office will file your claims for you and assist you in every way possible to ensure benefit recovery. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. **Felicijan Chiropractic Office will not enter into a dispute with your insurance company over policy limitations or issues**. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Felicijan Chiropractic Office cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. Felicijan Chiropractic Office will contact your insurance provider to verify your policy benefits; however, the benefits quoted to Felicijan Chiropractic Office by your insurance company are not a guarantee of payment. It is Felicijan Chiropractic Office policy that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays at time of service in full.

Work Compensation/Auto Accident

You will be responsible for bringing in insurance information regarding your WC/Auto accident. Present all forms (employer/medical/accident report) and adjustor's information that pertain to the incident. You are responsible for informing your employer/insurance ahead of time. Most payments will come directly to Felicijan Chiropractic Office but if not, you will be responsible for full payment at time of service. An Attorney Lien will be singed on the start of your care in auto accidents. If a third-party insurance is involved, you will pay services on the same day as care. All Doctor's notes will be submitted along with billing. Whatever expenses that are not paid by the insurance will be your responsibility. If you wish to submit rendered services to your personal health insurance after Felicijan Chiropractic Office has billed the initial auto insurance, Felicijan Chiropractic Office will be more than happy to supply information needed to bill yourself. Benefit coverage is not guaranteed therefore if we do not receive payment after claims have been billed, the rendered balance is your responsibility. Felicijan Chiropractic Office will consider sending claims to collections if not resolved within a 90-day period after all avenues exceeded.

CONFIDENTIAL PATIENT HEALTH RECORDS

Patients without Insurance

Felicijan Chiropractic Office request that **100%** of the services (examination, x-ray, etc...) be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time-of-Service Reduction in fees you must pay on the day the service was performed. Felicijan Chiropractic Office is happy to accept cash, check, and credit card. No insurance will be billed.

Medicare

Felicijan Chiropractic Office **does not** accept assignment from Medicare. Reimbursement is sent to you directly in payment for chiropractic services that Medicare will cover and you are expected to pay at time of service. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services which Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Supplemental/Union Insurance

Please inform Felicijan Chiropractic Office of any secondary insurance you may have. Felicijan Chiropractic Office will file and collect from your secondary insurance for services covered by the secondary payer. Some secondary insurance will send payment to patient in which you will be responsible for paying charges at time of service.

Office Policy

Please read the following regarding assignments:

At the beginning of your treatment in Felicijan Chiropractic Office will verify your policy benefits. However, internet, phone or fax verification of coverage is never a guarantee of payment.

1. Returned checks and balances over 90 days may be subject to additional fees and an interest charge of **18%** per month and a $1 statement fee. Charges may also be made for missed appointments and those canceled without 24 hours' notice.
2. Your insurance will be filed as a courtesy to you. Felicijan Chiropractic Office files insurance claims on a weekly basis. Patient is responsible for giving any updated information regarding insurance changes.
3. You will be responsible for your full deductible and co-payment or coinsurance. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are of aware of the denial.
4. If you pay the full amount for services rendered each visit, you may qualify for our Time of Service (TOS) discount. You may then submit the bill to your insurance company for reimbursement.
5. **If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance.**
6. Our fees are considered usual and customary by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

I_____ understand and agree with the statement above and acknowledge my responsibility.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____